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FORCED MEDICATION IN PSYCHIATRY: PATIENTS' RIGHTS AND THE LAW NOT RESPECTED BY APPEALS BOARD IN DENMARK

Peter C. Gøtzsche, Simon Vinther, and Anders Sørensen

Abstract

Objective: We investigated if the law and the patients' rights are being respected in Denmark when patients appeal forced medication orders.

Method: We assessed 30 consecutive cases described on the webpage of the Psychiatric Appeals Board.

Results: No clear and convincing evidence was presented in any case that the proposed treatment was in the patient's best interests. Furthermore, according to Danish law, forced medication should be with drugs with the fewest possible adverse effects, but this condition was violated in 29 of the 30 cases (97%).

In seven cases (23%), where the board disagreed with an earlier decision made by the Psychiatric Patients' Complaints Board and resolved that the conditions for forced treatment with an antipsychotic had not been met, the issues were formal and minor, and the Appeals Board argued, also in these cases, that force was justified because the patient was insane and that the prospect of cure or a significant and decisive improvement in the condition would otherwise be significantly impaired. This view lacks support in reliable science.

The board seems mainly to have a cosmetic function, rubber stamping what the psychiatrists want. It focused on uncontroversial issues it could easily check and not on what is important for patients.

Conclusions: Patients' rights and the law were not being respected. We suggest forced medication be abandoned, in accordance with the United Nations Convention on the Rights of Persons with Disabilities.

Key words: forced treatment, human rights

Peter C. Gøtzsche, Simon Vinther, and Anders Sørensen

Institute for Scientific Freedom, Copenhagen
https://www.scientificfreedom.dk/

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Corresponding author
Peter C. Gøtzsche
E-mail: pcg@scientificfreedom.dk

Introduction

Forced admission and forced treatment orders in psychiatry are regulated by law but these measures are highly controversial, for two main reasons.

Firstly, they violate basic human rights and discriminate against psychiatric patients. The fundamental human right to equal recognition before the law applies to everyone, also to people with mental disorders (United Nations, 2014). In 2014, the United Nations specified that member states must develop laws and policies to replace regimes of substitute decision-making by supported decision-making, which respects the person's autonomy, will and preferences and abolish laws that permit forced treatment (United Nations, 2014). People have the right to be free from involuntary detention in a psychiatric facility and not to be forced to undergo forced treatment. The convention has been ratified by virtually all countries, but as far as we know, no initiatives have been taken anywhere to abolish laws of forced admission and treatment.

Secondly, as we shall discuss in detail below, it is not clear that forced treatment is in the patients' best interests (Gøtzsche, 2015). This view has been put to a test in court cases. In *Myers v. Alaska Psychiatric Institute* (138 P.3d 238, 254; Alaska 2006), the Alaska Supreme Court held that, in non-emergency cases under AS 47.30.839, a court may not permit a treatment facility to administer psychotropic drugs unless in addition to the statutory requirements, the court expressly finds by clear and convincing evidence that the proposed treatment is in the patient's best interests and no less intrusive alternative is available (Gøtzsche, 2015).

In *Bigley v. Alaska Psychiatric Institute,* the Alaska Supreme Court held that a less intrusive alternative is available if it is feasible, in which case the hospital must provide it or release the person (208 P.3d 168, 182, Alaska 2009) (Gøtzsche, 2015). *Bigley* also held that when seeking the involuntary administration of psychotropic medication under AS 47.30.839, the petition must provide a plain, concise and definite written statement of the facts underlying the petition, including the nature of and reasons for the proposed treatment and information about the patient's symptoms and diagnosis; the medication to be used; the method of administration; the likely dosage; possible side effects, risks and expected benefits; and the risks and benefits of alternative treatments and nontreatment (208 P.3d at 188).

These victories for human rights have not had any consequences for psychiatric practice, not even in Alaska. On June 1, 2016, Peter Gøtzsche testified in a

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proceeding held in Anchorage and also reviewed four AS 47.30.839 petitions. They were strikingly similar and failed to provide the information required in the *Bigley* case. What was particularly disturbing was that the psychiatrists used a template (Table 1) where they ticked off that the conditions for forced treatment were met; the free text that was entered under 10 items was also remarkably similar for different patients.

The patient's prognosis without the medications was always stated as being poor whereas it was good with the medications, and the patients had apparently not experienced any side effects from the drugs. This seemed highly unlikely for the patient discussed in court who was in treatment with olanzapine, haloperidol, lorazepam and diphenhydramine, all to be given both as injections and orally, plus valproate and benztropine orally. Gøtzsche

Table 1. *Petition form used by psychiatrists in Anchorage in 2016 (typos as in original)*

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

In the Matter of the Necessity	)	
for the Hospitalization of:	)	
	)	Case No. PR
	)	PETITION FOR COURT APPROVAL OF
Respondent.	)	ADMINISTRATION OF PSYCHOTROPIC
	)	MEDICATION [AS 47.30.839]

_____

_____ petitioner, requests a hearing on the respondent's capacity to give or withhold informed consent to the use of psychotropic medication, and alleges that:

□ There have been, or it appears that there will be, repeated crisis situations requiring the immediate use of medication to preserve the life of, or prevent significant physical harm to, the patient or another person. The facility wishes to use psychotropic medication in future crisis situations.

□ Petitioner has reason to believe the patient is incapable of giving or withholding informed consent. The facility wishes to use psychotropic medication in a non-crisis situtation.

□ Court approval has been granted during a previous commitment period, and the facility wishes to continue medication during the subsequent commitment period. A 90/180 day petition is being filed. The patient continues to be incapable of giving or withholding informed consent.

The patient □ has refused □ has not refused the medication.

1. The patient's current diagnosis:
2. The petitioner's opinion is that administration the following psychotropic medication is in the respondent's best interest:
3. Possible significant side effects:
4. These medications are expected to treat the following symptoms:
5. The patient's prognosis with this course of treatment:
6. The patient's prognosis without these medications:
7. Of the medications requested, the patient has previously taken the following medications and experienced these results or side effects:

ITMO Hosp.: Case No.:

Petition for Court Approval of Administration of Psychotropic Medication Page 2 of 3

8. The following less intrusive treatment options/ alternatives are available:
9. I, the petitioner, have discussed the medication options with the patient yes.
10. The patient has3 been provided a copy of the relevant medication fact sheets by:

Date: _____ _____
Signature

_____
Printed Name

pointed out the flaws and erroneous statements and that the combination of drugs was dangerous, but to no avail; the judge upheld the petition for forced treatment. The proceeding was a farce that made a mockery of the patient's human rights.

In Norway, the Ombudsman concluded in December 2018 that the Psychiatry Act had been violated in a concrete case of forced treatment with an antipsychotic (Gøtzsche, 2019). Forced drugging is only allowed when, with "high probability, it can lead to recovery or significant improvement in the patient's condition, or if the patient avoids a significant worsening of the disease." Other countries have similar laws. "High probability" for a significant improvement means considerably more than 50%. Referring to the science, the Ombudsman noted that the probability of achieving the intended improvement is only 10-20%, which means that for decades, unlawful decisions about forced drugging have been made. However, despite his ruling, forced drugging continues unabated in Norway and is still actively supported by the health authorities.

We investigated if the patients' rights and the law for psychiatric patients (Bekendtgørelse, 2019) are being respected in Denmark.

Methods

In Denmark, a patient can complain about forced medication to the Psychiatric Patients' Complaints Board, and if the decision is upheld, the patient can appeal to the Psychiatric Appeals Board whose decision is final. The next step would therefore be to launch a court case, which rarely happens.

We tried to identify 30 consecutive cases of forced medication at the city court of Copenhagen, but this proved impossible. There were no electronic records and no indexing system existed that would enable us to find such cases.

We therefore contacted the Psychiatric Appeals Board, which referred us to their webpage (https://stpk.dk/da/afgoerelser/afgoerelser-fra-psykiatrisk-ankenaevn/) where they describe the cases anonymously. Thus, our research was limited to what the board had chosen to focus on. Our own interests were prespecified in our study protocol, inspired by the court cases in Alaska:

1. Was there clear and convincing evidence that the proposed treatment was in the patient's best interests and that no less intrusive alternative was available?
2. Was it documented that the patient could not provide informed consent?
3. Was the information about the psychiatric drugs the patient took or would be forced to take accurate?
4. Was the combination of drugs the patient took or would be forced to take safe?
5. Were the arguments for using force reasonable and documented?
6. Had the patient's rights been respected?
7. Were there striking similarities from case to case?

Results

We reviewed 30 consecutive appeals about forced medication processed at the Psychiatric Appeals Board between 10 May and 13 September 2017. The website material consisted of the board's comments. There was no original material from the patients' files, their complaints to the board, or expert assessments by psychiatrists. The median year of birth for the 30 patients was 1970 (range 1935 to 1996) and 16 were males; all were considered insane. This is the term used in Danish law; there were clear signs of psychosis in 21 patients and possible psychosis in the remaining 9.

According to Danish law, forced medication should be with drugs with the fewest possible adverse effects (Bekendtgørelse, 2019). However, only in one case was a benzodiazepine (diazepam 10 mg injection) discussed, even though antipsychotics are more toxic. Furthermore, in 15 of the other 29 cases, the forced medication was olanzapine, although this drug is known to be more harmful than other antipsychotics and was not recommended in official guidelines (Rådet, 2016). The board did not provide any criticism of this practice.

The drugs in the remaining 14 cases were: risperidone 6, zuclopenthixol 3, paliperidone 3, quetiapine 1 and aripiprazole 1. Four of the 30 cases involved an injection, in three cases a depot injection. In 21 cases, an injection with an antipsychotic was listed as an additional possibility; in 6 of these cases, with the same drug as the primary one.

A chief psychiatrist must try to motivate the patient daily to accept the treatment voluntarily, and the patient must be given sufficient time to think about it and to consult a patient counsel before force is applied. Three days are the norm, but the psychiatrist may decide otherwise, e.g. in acute situations where postponement of treatment "is endangering the patient's life or health." The median motivation time was three days.

It is required by law that a patient subjected to compulsory medication must be assigned a patient counsel, but in nine cases the board did not ensure that this condition was met, or that the patient had had the possibility to contact a counsel (three cases), but only assumed it.

Conditions for forced treatment not being met

In seven cases (23%), the Appeals Board disagreed with the Complaints Board and resolved that the conditions for forced treatment with an antipsychotic had not been met.

In two cases, the dose exceeded the recommended dose range and the patients' files did not provide any reasons for this; furthermore, the patients had not been properly informed. In a third case, the forced dose was higher than the dose offered during the motivation phase. In a fourth case, the Complaints Board was asked to reassess the case because of a dose error of a factor 10.

In one case, the patient had not been sufficiently motivated, and the situation was not acute; in another case with insufficient motivation, the patient had not been informed that the daily dose must be divided in two doses. In one case, there were no notes in the patient's file about the forced treatment and no name of a chief physician ordering it.

Other issues

In one case, the Appeals Board upheld the Complaints Board's decision about force although it was not justified to use force without delay to prevent danger towards the patient or others; furthermore, there was no date for the decision in the protocol and no name of the deciding physician, which is obligatory information.

Another case where the Appeals Board accepted force was also debatable. The patient's mother had informed the board that diazepam made the patient

aggressive, which the patient had confirmed. The board nonetheless accepted the injection with 10 mg diazepam based on the fact that there were no notes in the patient's file about his intolerance for that drug.

In one case where the psychiatrist had complained about the Complaints Board's decision against using force, the Appeals Board upheld the decision because it was not made clear in the patient's file that acute treatment was needed.

We could not assess whether the information about the psychiatric drugs the patient took or would be forced to take was accurate, as there was no information about this on the website. It was not documented in any case that the patient could not provide informed consent.

Discussion

The Psychiatric Appeals Board seems mainly to have a cosmetic function, rubber stamping what the psychiatrists want. It focuses on uncontroversial issues that are easy to check, e.g. if there was a date and name of the chief psychiatrist ordering forced treatment; if the patient was motivated daily for three days; and if the patient was informed about the intended dose range. There were striking similarities from case to case, with copy and paste from earlier cases, e.g. "The Appeals Board finds, after an overall assessment, that xx was insane and that it would be irresponsible not to coerce her, since the prospect of her cure or a significant and decisive improvement in the condition would otherwise be significantly impaired. The board has hereby emphasized that xx was in a psychotic state characterized by delusions."

In all cases where the board rejected the use of force, the reasons were formal and pretty trivial, and the board argued, also in these cases, that force was justified. It never considered, like the Norwegian Ombudsman did (Gøtzsche, 2019), whether its decisions were unlawful because there was no scientific support to the idea of using force to obtain a cure or a substantial improvement in the condition (Gøtzsche, 2015).

In a system like this, the patients' chance of avoiding forced medication is virtually non-existent. The patients were "motivated" to take antipsychotics "voluntarily" knowing all too well that if they refused, they would get the drugs anyway. We find it deeply disappointing that the board does not deal with the real issues, particularly considering that it consists of a judge, two psychiatrists, and two people from the Danish handicap organisations (Psykiatriske, 2019).

One issue which should have caused the two psychiatrists on the board to object was that the law's requirement about using drugs with the "fewest possible side effects" (Bekendtgørelse, 2019) was violated in 29 of the 30 cases (97%). Firstly, the official Danish guideline recommends six drugs as first- or second-line treatment, and olanzapine and zuclopenthixol (18 cases) are not among them (Rådet, 2016). For olanzapine, the guideline warns against a high occurrence of metabolic side effects and sedation, and for zuclopenthixol, dose-dependent extrapyramidal side effects and prolactinaemia. Secondly, benzodiazepines are less toxic than antipsychotics, and in 14 trials that compared them, the desired sedation occurred significantly more often on benzodiazepines (Dold et al., 2012).

The Danish practice would be considered unacceptable by the Alaska Supreme Court because no clear and convincing evidence was presented in any case that the proposed treatment was in the patient's best interests and that no less intrusive alternative was available (Gøtzsche, 2015), which it was in 97% of the cases. No evidence at all was presented. In several cases, the patients' psychotic symptoms were mentioned, and it was inferred that, because of these symptoms, the patients needed treatment with an antipsychotic. This cannot be concluded. Antipsychotics have no specific effects on psychosis; they are nothing but major tranquillizers, which was their original name (Gøtzsche, 2015). Further, they have no relevant effect on psychosis. The minimal improvement corresponds to about 15 points on the Positive and Negative Syndrome Scale (PANSS) (Leucht et al., 2006), but what was obtained in recent placebo controlled trials in submissions to the FDA was only 6 points (Khin, Chen, Yang, Yang & Laughren, 2012), even though the trials were seriously biased (Gøtzsche, 2015) and though it is easy for scores to improve quite a bit if someone is knocked down by a tranquillizer and express their abnormal ideas less frequently (Moncrieff, 2013).

According to Danish law, compulsory hospitalization or compulsory detention, which often leads to compulsory medication, may only take place if the patient is insane or in a state which must be equated with it, and it would be irresponsible not to deprive the person of his liberty for the purpose of treatment because 1) the prospect of cure or a significant and decisive improvement in the condition would otherwise be significantly impaired; or 2) the person presents an imminent and significant danger to himself or others (Bekendtgørelse, 2019).These ideas, and the way the law is being interpreted, are not sustainable. Firstly, psychiatric drugs are not curative; they can only dampen certain symptoms (Gøtzsche, 2015).

Secondly, their effect is so doubtful that it is impossible to claim, with scientifically valid arguments that would hold in a court of law, that the prospect of cure or a significant and decisive improvement in the condition would otherwise be significantly impaired. While the psychiatrists deny this fact, the patients, their relatives and the general public see it differently. A survey of 2,031 Australians showed that people thought that antidepressants, antipsychotics, electroshock and admission to a psychiatric ward were more often harmful than beneficial (Jorm et al., 1997).

We believe the general public is correct. Antipsychotics seem to reduce the prospect of a significant improvement, which is the opposite of their intended effect. The treatment of first-episode psychosis illustrates this. It is very different in Stockholm and the Finnish part of Lappland: 93% of 71 patients in Stockholm received antipsychotics initially (Svedberg, Mesterton & Cullberg, 2001), compared to only 33% of 72 closely similar patients in Finland (Seikkula et al., 2006). Ongoing antipsychotics were used in 75% vs. 17%, and after five years of follow-up, 62% vs. only 17% were on sick leave or received disability allowance.

In the World Health Organization's (WHO) large ten-country study of schizophrenia, about 64% of the patients in poor countries were asymptomatic and functioning well after five years compared with only 18% in the rich countries (Jablensky et al., 1992; Whitaker, 2015). As Western psychiatrists dismissed the results with the argument that patients in poor countries might have milder disease, the WHO did another study, focusing on first-episode schizophrenia diagnosed with the same criteria in ten countries (Whitaker, 2015). The results were similar, about two-thirds were okay after two years in the poor countries versus only one third in the rich countries. The WHO investigators tried to explain this huge difference by various psychosocial

and cultural factors but the most obvious explanation, drug use, went unexplored. People in poor countries couldn't afford antipsychotics, so only 16% of patients with schizophrenia were regularly maintained on antipsychotics as compared with 61% in rich countries (Whitaker, 2015). A more recent study performed by Eli Lilly that sells olanzapine failed to find differences between poor and rich countries, but in this study all patients were treated with drugs (Haro et al., 2011).

In a pivotal randomised trial with seven years follow-up, the only one of its kind, the patients who had their dose decreased or discontinued fared much better than those who continued taking their antipsychotic: 21 of 52 vs. 9 of 51 had recovered from their first-episode schizophrenia (Wunderink, Nieboer, Wiersma, Sytema & Nienhuis, 2013).

Thirdly, psychiatric drugs can only very rarely reduce a danger the patient presents to himself or others, e.g. if he is in a delirious state, is extremely agitated, or has developed akathisia, which predisposes to both suicide, violence and homicide (Gøtzsche, 2015). Akathisia does not occur spontaneously, but is a harm caused by psychiatric drugs. Many types of psychiatric drugs, including antipsychotics, can cause suicide and violence via this mechanism (Breggin, 2007 and 2013; Gøtzsche, 2015 and 2016; Hengartner & Plöderl, 2019; Moore, Glenmullen & Furberg, 2010). As noted above, a systematic review of psychotic patients showed that the desired sedation occurred significantly more often on benzodiazepines than on antipsychotics (Dold et al., 2012). It might therefore be argued that if acutely disturbed patients need more than psychological and psychosocial support to be calmed down, they should be offered a benzodiazepine, in high enough doses.

Conclusions

The patient's rights were not respected. The procedures used in Denmark violate the United Nations Convention on the Rights of Persons with Disabilities, which Denmark has ratified, and the requirement by Danish law about using drugs with the fewest possible side effects. We believe there is convincing evidence that forced medication in psychiatry leads to more harm than good, and we therefore suggest that forced medication be abandoned.

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