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Liberty and Tardive Dyskinesia: Informed Consent to Antipsychotic Medication in the Forensic Psychiatric Hospital

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ABSTRACT: This paper addresses informed consent to antipsychotic medication of those incarcerated in a forensic psychiatric hospital. The ways in which the unique setting of the forensic psychiatric hospital impinge upon the three components of informed consent—information, voluntariness, and competency—are explored. Special attention is given to the risk-benefit ratio of receiving antipsychotic medication in terms of the liberty interests at stake—freedom of movement, that is, the effects of tardive dyskinesia, and freedom of space, that is, release from the forensic psychiatric facility.

KEYWORDS: psychiatry, mental illness, informed consent, tardive dyskinesia, antipsychotic medication, coercion, competency, forensic psychiatric hospital

Concern regarding both the potentially crippling effects of tardive dyskinesia (TD) upon individuals receiving antipsychotic medication and the legal liability for the prescription of such medication has led to vigorous interest in the doctrine of informed consent to antipsychotic medication [1–9]. Articles discussing informed consent to antipsychotic medication have been primarily concerned with either outpatients or patients in general psychiatric facilities. Little, however, has been written regarding informed consent to such treatment in a forensic psychiatric hospital. This paper addresses informed consent to antipsychotic medication in individuals committed to a forensic psychiatric hospital and informed consent to antipsychotic medication of individuals in a forensic facility who are afflicted with TD.

The impetus for this paper was a clinical dilemma encountered recently at Kirby Forensic Psychiatric Center in New York State. Incarcerated in this hospital was a man diagnosed as suffering from schizophrenia, paranoid type, who was confined subsequent to having been adjudicated dangerous and mentally ill by the Supreme Court of New York and who was grossly psychotic. Despite a prolonged period of nonpharmacologic treatment, his psychosis had not improved. Without treatment with antipsychotic medication, which had resolved his psychosis during past forensic psychiatric hospitalizations, he most likely faced a prolonged period of incarceration and deprivation of freedom. With such treatment he faced a possible worsening of his TD and potential immobilization

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by uncontrollable movements. Whether this man was capable of giving informed consent to antipsychotic medication became a subject of vigorous debate among the members of the treatment team.

Duration of Treatment in the Forensic Psychiatric Hospital

The forensic psychiatric hospital is a unique facility whose resident population is composed of individuals who are confined as a result of their involvement in the criminal justice system. Within the forensic psychiatric facility are individuals whose competency to stand trial is to be evaluated; individuals adjudicated to be incompetent to stand trial; individuals found not responsible for their criminal acts by reason of mental illness or defect (not guilty by reason of insanity), who are to be evaluated as to whether they are dangerous (and mentally ill); and individuals adjudicated to be dangerous (and mentally ill). Most individuals found incompetent to stand trial remain in such a facility until they become competent. In theory, this may be for the remainder of the person's life. In practice, it is often for many years. With the U.S. Supreme Court ruling in *Jackson v. Indiana* [10] that an individual may be incarcerated in a forensic psychiatric facility for no longer than the reasonable period of time necessary to determine whether there is a substantial probability of the individual regaining competency to stand trial in the foreseeable future, lifetime incarceration for incompetency is now rare. Nevertheless, petition for release under the *Jackson* ruling may not occur for years, and thus even with the *Jackson* ruling, individuals may remain incarcerated for a lengthy period. Twenty-five states also have statutes which limit the length of incarceration of incompetent individuals [11]. In New York, for example, an incompetent individual charged with a felony may remain in a forensic psychiatric facility for no longer than two-thirds of the maximum time mandated for the act for which he or she is accused. Individuals alleged to have committed acts punishable by life imprisonment thus may potentially remain interminably in a forensic psychiatric hospital. The adjudication that an individual is dangerous and mentally ill can also result in a life sentence, since individuals so adjudicated may remain in a forensic psychiatric hospital unless or until they are later found to be no longer dangerous and mentally ill [12]. There is no *Jackson* equivalent in such cases.

Many psychiatrists believe that most cases of incompetency to stand trial and ongoing dangerous mental illness are the result of psychosis. Therefore, psychosis, particularly for those adjudicated not responsible by reason of mental illness or mental defect, is ultimately the individual's jailer, and only diminution or resolution of the psychosis will open the facility gates. Liberty or, in the case of those found incompetent to stand trial, potential liberty minimally requires successful treatment of psychosis. Reciprocally, no treatment or unsuccessful treatment of psychosis in the forensic psychiatric setting is a bar to liberty.

Discussion

Tardive Dyskinesia

It is generally accepted that antipsychotic medication is the most effective treatment for most psychotic states [13]. Antipsychotic medication may also cause tardive dyskinesia. Among individuals treated with antipsychotic medications, the prevalence of TD, when corrected for the spontaneous risk rate of dyskinesias, is approximately 20% [14,15]. In certain subgroups, however, TD may have a much higher prevalence. Chronically institutionalized patients, for example, have been shown to have a prevalence of TD of up to 59% [16]. Although most cases of TD are not severe or disabling, there may be a myriad of distressing symptoms. These include marked grimacing, body contortions,

instability of posture, and gait disturbances which may lead to falls and injuries. Severe TD, the prevalence of which is unclear, may significantly impair respiration. There are reports of dyspnea, chest pain, and life-threatening respiratory and gastrointestinal complications. Speech impediment and weight loss in patients with severe generalized TD also have been described. Irreversible (or apparently irreversible) TD may be so demoralizing as to produce increased suicide potential [17].

It is not possible to predict accurately who will develop TD. Age, sex, and duration of treatment with antipsychotic medication most strongly correlate with the development of TD. In a major epidemiologic review, older women (there is no clear definition of "older") treated for many years (there is not clear definition of "many") were shown to be most likely to develop this malady [14]. The percentage of cases of TD that are fully reversible is unclear [14,16]. However, one study found that the incidence of TD which persists for at least six months following four years of cumulative exposure to neuroleptics is 11% and that the incidence of persistence (six months) of TD following eight years of cumulative exposure is 22% [18].

There is no satisfactory treatment for TD. Masking of the movements by increasing the dose or restarting antipsychotic medication cannot be considered to be curative. Questions regarding the likelihood of progression and the degree of progression of TD with continued use of antipsychotic medication or the reinstitution of antipsychotic medication after a medication-free period remain unsolved. Knowledge of the effects of continued treatment with antipsychotic medication is limited to the general observations that TD is more likely to persist in older individuals and that the prognosis of TD is better for individuals treated for shorter periods at lower doses [18]. At best, "the prediction of prognosis for the individual patient remains problematical" [16].

Informed Consent

Review of the literature revealed no cases specifically addressing the issue of informed consent to treatment with antipsychotic medication of individuals with TD incarcerated in a forensic psychiatric hospital. An incarcerated individual's ability to give informed consent to treatment with potentially crippling, irreversible side effects or "experimental" psychosurgery, however, has been addressed in the landmark case of *Kaimowitz v. Department of Mental Health of the State of Michigan* [19]. An involuntarily hospitalized individual's right to refuse antipsychotic medication has been addressed in *Rennie v. Klein* [20], *Rogers v. Okin* [21], and *Rivers v. Katz* [22], cases all involving civilly hospitalized patients. Although nonprecedential and problematic, *Kaimowitz* will nevertheless be utilized as a foundation for the analysis of informed consent to treatment with antipsychotic medication because (1) it addresses the case of an individual hospitalized, unlike the previously cited cases [20–22], as a result of involvement in the criminal justice system, whose freedom may be dependent upon receiving a treatment about which limited information is available, and (2) this case specifically addresses each component of informed consent to treatment—information, voluntariness, and competency. In contrast, right-to-refuse cases [20–22] focus solely upon the involuntarily hospitalized patient's competency to choose whether to take antipsychotic medication, and these cases address neither voluntariness, which may be different in a forensic psychiatric facility, nor the level of information required to make an informed decision, particularly in high-risk situations, for example, when there is preexisting TD. This case will be utilized as a foundation for the analysis of informed consent to treatment with antipsychotic medication of individuals in a forensic psychiatric hospital.

In *Kaimowitz*, John Doe, who had been charged with murder and rape and who had been committed to the Ionia State Hospital, had agreed, after more than 17 years of incarceration, to undergo experimental psychosurgery as a subject in a study of uncon-

trollable aggression. Prior to his agreement to participate in the study, John Doe had signed a detailed informed-consent form. Although the research project was discontinued by its investigators and psychosurgery was never performed, Kaimowitz, a legal services attorney, asked the court to issue a declaratory judgment as to whether “an adult or legally appointed guardian, if the adult is involuntarily detained at a facility in the jurisdiction of the State Department of Mental Health, can give legally adequate consent to an innovative or experimental surgical procedure on the brain. . . .” The court ruled that psychosurgery may never be undertaken upon such involuntarily admitted populations because of the impossibility of obtaining truly informed consent from such populations.

Consent was judged not to be voluntary since mental patients involuntarily confined for an indeterminate period were deemed to live in an inherently coercive institutional environment. Individuals cannot voluntarily give informed consent, it was stated, to psychosurgery because they are subject to ulterior forms of restraint or coercion when their release could potentially depend on their consenting to the surgery. The inequality in their position was felt to prohibit voluntary consent. In addition to John Doe’s inability to consent voluntarily, the court ascertained that the facts surrounding psychosurgery were so “uncertain” as to also prohibit the making of an adequately informed decision.

In perhaps its weakest argument, the court ruled that John Doe and the class of involuntarily confined mental patients lacked the capacity to make a competent decision on the subject. Incarceration and the attendant institutionalization were deemed sufficient to rob mentally ill patients of their ability to make a competent decision on this matter.

In reaching its decision, the court also considered the risk-benefit ratio of experimental psychosurgery. As discussed by Roth et al. [23], the threshold for competency, and, by implication, informed consent, is generally set directly proportional to the risk-benefit ratio of the treatment in question. The risk-benefit ratio of psychosurgery was felt by the court to be quite high. Psychosurgery was seen to be experimental, to pose substantial danger to its recipient, and to carry significant unknown risks. Furthermore, psychosurgery, in accordance with expert testimony presented, was felt by the court to be unable to assure the patient that it could change a dangerously violent person sufficiently to allow his or her safe return to the community, one of the goals of this procedure. It was also determined that this procedure was of uncertain benefit to society’s interest in learning more about the underpinnings of deviant behavior. Accordingly, a high standard for informed consent to this procedure—higher, for example, than that for a commonly performed neurosurgical procedure upon an institutionalized patient—was set by the court. This standard was not met, and by not permitting psychosurgery, the court protected—in its view—“one of a person’s greatest rights . . . the right to inviolability of . . . person.”

The Forensic Psychiatric Hospital and Treatment with Antipsychotic Medication

The risk-benefit ratio of treatment with antipsychotic medication of psychotic individuals, who are free of TD, in a forensic psychiatric hospital is clearly lower than that of the *Kaimowitz* case. In both instances, the potential benefit is exceedingly high—liberty. The realization of this benefit, however, is probably far greater with antipsychotic medication than with psychosurgery. Antipsychotic medication is a well-documented, effective treatment for psychotic states [13]. Psychosurgery remains an experimental treatment whose efficacy for violent sexual offenders is unclear. The most serious risk of antipsychotic medication, TD, is, however, significant. How this risk compares with that of psychosurgery is not altogether clear because knowledge of TD (for example, who will actually develop it, its natural history) is limited, as is knowledge of the risks of psycho-

surgery (for example, apathy, hostility) [24]. However, at the very least, after years of clinical experience and research, the most significant risk of antipsychotic medication is probably known, whereas that of psychosurgery may not be. As evidenced by the high prevalence of use of antipsychotic medication in forensic psychiatric hospitals, the benefits of antipsychotic medication for physically healthy individuals facing possibly prolonged incarceration greatly outweigh its risks.

The degree to which the decision to take antipsychotic medication in a forensic psychiatric hospital is a voluntary one requires exploration. Patients in such a setting sometimes cooperate with their doctors out of the fantasy (and perhaps sometimes reality) that their cooperation will please or placate their doctors and result in the submission of a more favorable report to the court. Conversely, patients sometimes fear that discordance with their doctor's wishes will result in retaliation by the doctor who possesses the power, in the form of psychiatric-legal reports and testimony, to prolong an individual's incarceration. Coercion, although present, is probably less than that described in the *Kaimowitz* case. Unlike the situation in the *Kaimowitz* case, antipsychotic medication is prescribed by the patient's treating physician, who in theory possesses a therapeutic alliance with the patient and lacks ulterior motivation for providing treatment. The treating physician's primary goal is to diminish the patient's mental illness. In *Kaimowitz*, one of the primary motives of the researchers-surgeons was not, as it perhaps appeared to the study subjects, to aid them with their difficulties, but rather to complete their research project. Although patients' decision-making in a forensic psychiatric hospital is not fully voluntary and is probably less so than for involuntary patients in a civil facility, in contrast to the *Kaimowitz* case, there is a sufficient degree of voluntariness, when judged in accordance with the risk-benefit ratio of receiving antipsychotic medication, to make informed consent in this situation possible.

In contrast to the conditions for experimental psychosurgery, significant information is available concerning the use of antipsychotic medication in individuals without TD. Despite significant gaps in the understanding of TD, the relatively low risk-benefit ratio for the use of antipsychotic medication in patients without TD renders available information sufficient for making an informed decision.

The question of competency to make an informed decision must also be considered. Subsequent to the *Kaimowitz* decision several states declared that involuntarily hospitalized patients are competent to make treatment decisions regarding the use of antipsychotic medication unless judicially determined otherwise [20–22]. The issue in such states then is whether an individual patient, and not—as in *Kaimowitz*—an entire class of institutionalized patients, is competent to make an informed decision. For the treatment of psychosis in the forensic psychiatric hospital in cases in which the risk-benefit ratio is low, an easily reachable threshold for competency to take antipsychotic medication is desirable.

This analysis does not apply to patients who do not wish to be released from the forensic psychiatric hospital. For patients who do not desire their release, the risk-benefit ratio of receiving antipsychotic medication is appreciably altered. Commonly, such patients have been adjudicated unfit to proceed to trial and currently wish not to go to trial. These people fear, for nonpsychotic reasons, being sentenced to serve time in prison and prefer to remain in a forensic psychiatric facility until they are released via statutory requirement. From the perspective of these individuals, antipsychotic medication is of greater risk than benefit (for example, potential imprisonment in a more dismal, dangerous setting). Others may wish, for reasons that are derived from their mental illness, to remain in a forensic psychiatric facility. For such individuals, the risk-benefit ratio of receiving antipsychotic medication is not altered, since it is assumed that, were they not under the influence of their illness, they would desire liberty (or the potential for liberty).

Individuals with Tardive Dyskinesia

For individuals incarcerated in a forensic psychiatric hospital who already possess nondisabling TD, the most significant benefits to be derived from treatment with antipsychotic medication are diminution of psychosis and a greater chance of release from the forensic psychiatric hospital. A study by Bloom et al. [25] of patients in a non-forensic psychiatric hospital supports the notion that psychotic patients who receive antipsychotic medication have shorter hospitalizations than those who require but do not receive such medication. The most significant risk of this treatment is that of worsening preexisting TD and immobilizing individuals as a result of uncontrollable, involuntary movements. If such treatment is to be worthwhile, the likelihood of release from incarceration must significantly outweigh that of the production of disabling TD. Release achieved at the cost of crippling TD does not represent a meaningful increase in freedom.

Although the incidence of severe and disabling TD is low [14], little is known as to which patients with preexisting TD will upon renewed or continued exposure to antipsychotic medication develop severe, irreversible TD. The "present opinions on the natural course of TD are varied and conflicting" [14]. For example, although antipsychotic medication can promptly be discontinued upon signs of worsening of TD, it is not known whether there is a threshold of exposure beyond which TD will progress even after an individual no longer receives antipsychotic medication. It is known, however, that antipsychotic medication produces a significant diminution of psychosis in the majority of individuals in whom it is used [13]. Although statistics are lacking concerning the relationship between treatment of psychosis and release from the forensic psychiatric hospital, clinical experience indicates that a direct relationship does exist. This relationship may, however, be clouded by nonmedical issues. A judge, for example, may fail to order the release of an individual who has committed a particularly violent or heinous act, despite strong clinical evidence and psychiatric testimony that the individual is no longer psychotic and dangerous, for fear of public reproach and political disenfranchisement.

It already has been established that the coercive forces which exist in the forensic psychiatric hospital are not generally sufficient to negate an individual's ability to consent voluntarily to treatment with antipsychotic medication. Liability concerns (for example, the responsibility for worsening TD) may decrease coercive forces to take antipsychotic medication in cases in which an individual is already afflicted with TD. However, as the risk-benefit ratio of treatment with antipsychotic medication is greater for the individual who already has TD than for the individual who does not, a higher threshold for competency, in particular (and informed consent in general), in this situation is necessary. The vagaries of the effects of antipsychotic medication upon preexisting TD require the patient to make a relatively complex treatment decision. The patient competent to decide to take antipsychotic medication may no longer be competent to make this decision once he or she has acquired TD. To be considered competent, the patient should be able to understand that antipsychotic medication offers the promise of relief from her or his illness and of earlier release from incarceration, as well as the peril of significantly worsening the involuntary movement disorder. Although the risk of progression of TD with continued use of antipsychotic medication may be significant, most cases of TD never become severe, and therefore the criteria for competency should permit a majority of patients to make this treatment decision.

Conclusions

In this paper informed consent to antipsychotic medication of individuals incarcerated in a forensic psychiatric hospital with and without TD has been examined. Using the *Kaimowitz* case as a springboard and the risk-benefit ratio of treatment as a guiding principle, the three components of informed consent—voluntariness, information, and

competency—have been assessed in relation to antipsychotic medication, TD, and the setting of the forensic psychiatric hospital.

In the forensic psychiatric hospital, respect for autonomy of the individual manifested in the doctrine of informed consent must be balanced against respect for autonomy of the individual manifested by freedom from incarceration. In the case of psychotic individuals with TD, whose best hope for release from incarceration is antipsychotic medication, autonomous function may be compromised by the very treatment which promises freedom. One of the roles of informed consent in this situation is to help balance competing forms of autonomy. Balance may be more difficult to achieve for treatments which are of higher risk or more questionable benefit than antipsychotic medication. The number of individuals in forensic psychiatric hospitals who have not responded to "usual" treatment approaches and thus face potential lifetime incarceration is unknown. In *Kaimowitz*, informed consent ironically resulted in the withholding of the only available treatment which might have resulted in release and a significant gain in autonomous function. The innovative application of medications (for example, clozapine, anticonvulsants) or electroconvulsive therapy may offer select patients hope that other treatment modalities do not. The challenge to the role of informed consent in these situations is to support informed decision-making while permitting treatment that offers the possibility of release from the pain of mental illness and the bars of the forensic psychiatric hospital.

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