6 Ethical Issues Arising from the Prescription of Antipsychotic Medication in Clinical Forensic Settings

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6.1 Introduction

The physician must…have two special objects in view with regard to disease, namely, to do good or to do no harm. (Hippocratic Corpus, Epidemics, Book I, section XI)

The evolution of clinical psychiatry is a fascinating one. It is a journey that continues to develop, exploring new concepts and revisiting existing ones interchangeably. At its core lies a deep appreciation of humanity and for us to serve our profession well, this needs to remain central to how we practice. If, hidden amongst our other attributes, we lose our compassion, then we demean the very nature of what it is we strive to achieve. We lose sight of the human condition and we do our patients a grave disservice.

As clinicians we must ensure that our duty to our patients is respected and enforced. We should hold present in mind our ethical and moral duties at all times. The overriding principles of medical ethics are those of autonomy, beneficence (to seek to do good), non-maleficence (to do no harm) and a respect for justice. The issues however are complex and the principles are weighed against each other, seldom considered in isolation. As an example, the principle of non-maleficence goes hand in hand with the principle of beneficence. One is constantly balanced against the other, but because human communication is complex and context specific, balancing risk of harm against potential benefit will vary from person to person and sometimes for the same person at different times or in different circumstances. Such decision-making is further complicated by the fact that often the balance of risk and harm to an individual is only ultimately understood when viewed through a retrospective lens.

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If we take the principles of beneficence and non-maleficence and apply them to the practice of administering medication to patients detained against their will in secure settings, it becomes clear that the ethical dilemmas are manifold. As psychiatrists, and doctors foremost, we are in a unique position to try to ameliorate the psychological distress and suffering of those in our care. We have a number of tools at our disposal that can be employed to help treat our patients, the most potent of which in today's Western world is medication—specifically, antipsychotic medication.

Antipsychotic medication is a big player in the current climate. Prescription rates have never been higher and the toll of mental ill health never greater. The ethical principles that guide us in terms of delivery of care are central to the endeavour of prescribing treatment in the form of medication. We do this in an attempt to modify the behaviour of our patients, both in terms of ameliorating internal distress and reducing actual and potential violence. In so doing we may cause a direct risk to that patient's health.

We need to consider, therefore, with whom the responsibility lies in terms of judging the harm suffered. Equally important is determining to what extent a medication regime is deemed too risky. When, for example, is high-dose antipsychotic medication justified, and when is it malpractice? Being both mentally unwell and having committed harm to others in the wider community, our patients face significant social marginalisation. They are considered both as a risk to society and often as a risk to themselves. As forensic psychiatrists we need to be able to balance and weigh up the ethical obligations we have to the patients in our care and the ethical obligations we have to wider society in terms of management of risk. Never more apparent is this dual role than when prescribing and administering high doses of antipsychotic medication when consent to do so has been refused or revoked.

The advent of pharmacological agents designed with ever-increasing sophistication has led to increasingly optimistic predictions with regard to the alleviation of some of the distressing symptoms experienced by those suffering with severe and enduring mental illness. Whilst the expansion of the pharmacological industry offers cautious hope, it is countered with the knowledge that these medications carry a significant physical, psychological and societal burden. Ethical issues are inextricably linked to the act of prescribing antipsychotic medication, not least in terms of informed consent and capacity, but also in the face of wider societal constraints and financial ties to the pharmaceutical industry. The relationship with the industry is important to consider because it is unavoidable given the way in which research and development of new medications is carried out—the influence that the pharmaceutical industry has to potentially shape the science of psychopharmacology is great, and there is public feeling that financial ties, including recruitment incentives, serve to influence professional behaviour and thus medical care (Strous 2011). There are clear ethical problems when a treating psychiatrist accepts gifts from pharmaceutical companies, or agrees to use certain medications on the back of a financial incentive. It is likely that gifts given in the context of intensive advertising campaigns create an unconscious bias in that psychiatrist's prescribing practice. Insel states that the problem is greater in psychiatric practice than in medicine or surgery owing to the psychopharmacological focus of many pharmaceutical companies (Insel 2010).

Sales of antipsychotic medication in the Western world are huge, and they generate a large amount of income for the pharmaceutical companies. Some of this is in turn fed into further research and studies, so it is vital that prescribers are kept abreast of marketing practices and biases in therapeutic information (Strous 2011). The need to engage responsibly and ethically in the prescription and administration of these agents therefore remains of utmost importance.

6.2 The Rise of Antipsychotic Medication

Antipsychotic medication currently holds a central place in the treatment of many with psychiatric disorders and it at times tends to dominate much of what we do—certainly within secure settings where a major arm of the treatment arsenal comprises use of these agents. We can often find ourselves the deliverers of care by virtue of the drugs at our disposal—and this is where ethical mindfulness and sensitivity need to play a part in the decisions that we make.

Mental health care has historically made use of substances, both legal and illicit, with varying degrees of success. It was not however until the early 1950s that a French pharmaceutical company, investigating sedative drugs for use in surgery, discovered chlorpromazine. They found that it caused relaxation without significant drowsiness. The subsequent serendipitous discovery that chlorpromazine could also alleviate disordered thinking and behaviour was groundbreaking. It challenged the way in which mental illness was conceptualised and treated and in so doing gave psychiatric practice medical validity. Chlorpromazine paved the way for the search for other antipsychotic agents, and society became more aware about the use of antipsychotic medications and the way in which they worked.

The social impact of this was significant. Psychiatric symptoms started to be attributed to chemical imbalances rather than to any underlying psychological or emotional needs, which in part helped to reduce some of the stigma surrounding mental ill health. This was not merely a moral or spiritual affliction, a weakness of the mind—there had to be a neurobiological basis. This medicalisation of psychiatry served to swell the increase in the psychiatric drug market and fuelled research into the search for more potent pharmaceutical agents. This advancement in research helped to generate a better understanding of the pathophysiology of many mental processes. Although this understanding remains only partly understood, one thing became clear—antipsychotic medication was here to stay.

6.3 Use of High-Dose Antipsychotics and Polypharmacy in the Management of Severely Disturbed Offenders

We now prescribe antipsychotic medications to our patients with an awareness of the large evidence base that supports their use. We know that the medication can be used to good effect to reduce aggression arising from psychosis, but it is also used to try to reduce risk of future violence—something that can be very hard to

determine. Most of our patients have co-morbid psychiatric diagnoses—serious mental illness and personality disorders in combination, often compounded by longstanding substance misuse issues. This co-morbidity can help to explain why some are often slow to respond to treatment and frequently relapse. It also helps to explain why, in cases such as these, clinicians often resort to antipsychotic polypharmacy or high-dose antipsychotic monotherapy.

High-dose antipsychotic monotherapy arises when a clinician prescribes more than the recommended BNF (British National Formulary) maximum limit for one antipsychotic agent. Antipsychotic polypharmacy arises when two or more antipsychotic medications are prescribed to run concurrently. In the case of polypharmacy, the amount of medication can be determined by converting the dose of each antipsychotic medication into a percentage of the BNF maximum recommended dose for that medication and adding these together. A cumulative dose of more than 100% is deemed a high dose (College Report 2014). The reason that this is considered an issue is because at higher than recommended doses there are two major concerns—firstly, there is an increased chance that the risk–benefit ratio for the medication will be exceeded and that there will be harm caused to the patient, and secondly, the responsibility of any harm caused will be assumed by the prescriber and those that dispensed and administered it (the pharmacist and the nurse). So, is there an evidence base for going off the recommended prescribing piste, and if it is deemed a necessary route for treatment, what are the ethical considerations that need to be held in mind?

From a pharmacological perspective, there are two main reasons why higher doses of antipsychotics might be theoretically justified in some cases. The first reason is that individual patient differences in pharmacokinetics (how the body affects the medication) may lead to insufficient antipsychotic medication reaching the effect site. The second reason is that some patients have differences in their pharmacodynamics (how the medication affects the body), which might mean that higher doses of antipsychotic medication are required (College Report 2014).

We know that if psychosis is left untreated, or insufficiently treated, behaviours that manifest can be impulsive and aggressive, and these risk harm both to the patient and to others. We also know that patients can continue to behave in ways that are violent and impulsive even when the psychosis is under control. Most violence in forensic settings tends to be impulsive, and this can be mediated by antipsychotic medication (Warburton 2014). The impulsivity may arise from the psychosis itself, or may be separate to it. With the aid of neuroimaging, it has been demonstrated that at least 60% of the dopamine (D2) receptors need to be blocked by the antipsychotic medication in order for a reduction in the psychosis to be seen. At beyond 80% blockade the beneficial effect is less evident, and there is an increased (and often substantial) side effect burden. Interestingly, there is increasing evidence that in some patients with schizophrenia, symptoms do not seem to be driven through dysfunction of dopamine pathways, which would make increasing the dopamine blockade in such patients clearly futile (Taylor et al. 2015).

Not unsurprisingly, there is little evidence base to support the use of high-dose antipsychotic monotherapy or antipsychotic polypharmacy specifically to reduce

violence in the medium to long term (Goedhard et al. 2006). There is some evidence that suggests an association between prescriptions of higher antipsychotic dosage in patients who have a history of violence and who have also engaged in recent violent behaviour. Wilkie et al. found that patients with a history of aggression had a nine and a half times higher chance of being prescribed higher doses of antipsychotic medication, as did those patients who had a greater than 5-year history of antipsychotic medication prescription. Their conclusions surmised that the high-dose antipsychotic prescription related more to patients' past reputation of aggression and to prescriber differences, than to patients' current behaviour (Wilkie et al. 2001).

The current Maudsley Prescribing Guidelines reports that there is no firm evidence that high doses of antipsychotics are any more effective than standard doses. They note that in the UK, the vast majority of high-dose antipsychotic prescribing is through the cumulative effect of polypharmacy (Taylor et al. 2015). The guidelines recommend that the use of high-dose antipsychotics be an exceptional clinical practice (that is, not the norm) and that it should only ever be employed when an adequate trial of standard antipsychotic treatments, including clozapine, have failed. The main clinical rationale for prescribing combined antipsychotics is to improve residual psychotic symptoms. The guidelines however state that there is no good objective evidence that combined antipsychotics (that do not include clozapine) offer any efficacy advantage over the use of a single antipsychotic (Taylor et al. 2015).

The limited evidence base is likely a consequence of the fact that those patients requiring and receiving high dose antipsychotic medication are too unwell to take part in any clinical studies. Managing longer-term aggression and challenging behaviour is particularly complex given the multifactorial nature of the psychopathology in many cases (such as childhood conduct problems, victimisation history, social living situation and substance misuse) (Swanson et al. 2008).

As many as 30% of psychiatric patients receive antipsychotic polypharmacy at any one time (Längle et al. 2012). Current guidelines recommend that at least two trials of monotherapy be attempted, followed by a trial of clozapine prior to consideration of polypharmacy. If, as in some cases, polypharmacy is introduced as the rule and not the exception, what we see is an increase in side effect burden. High-dose antipsychotic treatment clearly worsens adverse side effect incidence and severity. The side effects of these medications are horrible and can become life-threatening. The evidence that these medications can cause harm is compelling. There are a number of published reports of clinically significant side effects such as an increased prevalence of extrapyramidal side effects, increased metabolic side effects, sexual dysfunction, increased risk of hip fracture, paralytic ileus, grand mal seizures, prolonged QTc and arrhythmias associated with antipsychotic polypharmacy (Taylor et al. 2015). This knowledge carries with it its own ethical bind. Medications used to help combat these side effects can themselves impact negatively, with anticholinergics (commonly used to help manage extrapyramidal side effects) causing, amongst other complaints, cognitive impairment. So the antipsychotic medication used to help moderate the behaviour carries risk to the patient, as does the medication used to counter this risk. What results is a constant, circular risk–benefit analysis.

What is it then that leads to high antipsychotic prescribing in the forensic population? There is often the assumption that it is a lack of response to lower doses and that the high doses are warranted in attempts to reduce the threat of future violent behaviour. Often these patients are deemed treatment resistant and their insight remains limited. In these cases, it is common for the medication to continue unabated. There is also the pressure to provide pharmacological treatment for those who are behaviourally challenging to manage, even when there is no strong evidence base to support the use of antipsychotic medication in the treatment regimen. The question to be asked therefore is what is it that we are treating—aggression predicated on historic risk, current risk or future risk? For many, it is treatment for all of the above, and sustained high-dose medication appears to be the answer.

6.4 What Ethical Issues Are Raised by the Use of High-Dose Antipsychotic Medication?

So how do we engage ethically in this psychopharmacological arena? The power that lies in the clinicians' hands is remarkable, particularly given the ability that these medications have to alter mental state and behaviour. It is clear that the ethical code underpinning this power is critical. It is no less important to understand how dopamine blockade alters the neurotransmitter balance than it is to obtain well thought through informed consent for the administration of the proposed antipsychotic medication. It has long been observed that injuries to patients may be caused by overmedication by doctors. Sometimes the disease process itself masks these injuries, and at other times they are attributed to side effects.

So, with this in mind, are we able to justify prescribing high doses of medications that we know have the ability to cause harm? If we are able to achieve a desirable outcome, by which I mean a reduction in the violent behaviour and a quietening of the patient's internal distress, then it could be argued that the treatment is justified because it is necessary (both in terms of the best interests of the patient and also in terms of reduction in risk of harm to others). However, an important question remains—is it morally right to achieve this outcome in the first place, and if it is, is it ethically acceptable to do so in this way? This is particularly relevant to ask in those that are behaviourally very challenging (for example, as a result of maladaptive personality traits) rather than those who are immediately challenging as a result of their (treatable) psychosis. The point here is that in those without clear evidence of an underlying psychotic process driving the behaviour, there is little scientific understanding of how the chemical action of the antipsychotic medication helps to moderate the behaviour. What we do know from clinical experience is that it can, and often does, help. But this is a controversial area and one that causes heated debate. It also stands to reason that in treating patients who present with challenging behaviour, outside the realm of psychosis, we are merely muting the behaviour and not treating the cause. This may be why we see long-stay forensic patients, in whom the psychosis has remitted but the challenging behaviour remains, on long-term maintenance therapy with antipsychotic medication. There

is an argument to suggest that in treating the behaviour, the patient is better able to develop their life in ways that increase their chance of discharge from hospital. There is a significant positive social impact too for reducing the level of aggression and violence that supports the rationale for prescribing high doses of antipsychotic medication, although this needs to be weighed up against the side effect burden that often ensues.

What I am saying therefore is that even if the antipsychotic medication, given against the patient's consent, causes them harm, the treatment itself may be comparatively less damaging to the patient than leaving the behaviour (whatever the underlying psychiatric cause may be) unchecked. What then arises, is deliberation about to whom the treatment is intended to benefit—society or the patients themselves? In the forensic arena, it is, more often than not, the potential risk to others that trumps any intended benefit to the patient.

Is the use of high-dose antipsychotic medication then a reasonable approach in terms of managing our patients? Does it deal merely with the expression of the aggressive behaviour? If this is the case, then it can only be ethically acceptable if it is not possible to treat the core problem from which the behaviour stems.

But we know that the side effect burden is significant when these medications are prescribed at high doses. Extrapyramidal side effects induced by antipsychotics are of significant clinical importance, not least because they have been shown to affect patients' quality of life negatively but also because they result in further stigmatisation. It is well documented that these effects reduce antipsychotic medication concordance because of this stigma, but also because of how unpleasant the side effects are for the patient. Extrapyramidal side effects can make people feel dysphoric, apathetic, emotionally withdrawn and cognitively slowed (Tandon and Jibson 2002). Other symptoms include akathisia (feelings of restlessness, inner tension and mental unease), which can be particularly unpleasant. Some studies have found that there is additionally a greater likelihood of suicidal ideation in those affected with akathisia (Seemüller et al. 2012).

With the prescription of antipsychotic medication comes an increased risk of cardiac arrhythmias and sudden death. These risks are heightened with higher doses and autonomic arousal, and also in some patient groups (for example, women, those with cardiovascular or liver disease and those also taking other drugs with cardiac effects or risky pharmacokinetic interactions (College Report 2014)). There is also evidence from two meta-analyses that reveal the higher the antipsychotic dose, the greater the effect on cognition, which gives direct support for the view that high antipsychotic dosage is detrimental to cognitive function. We know that anticholinergic agents might be required to treat the side effects, and so the detrimental effect on cognition is intensified (College Report 2014). The impact of being on high-dose antipsychotic medication is difficult to avoid, and this naturally has a detrimental effect on issues such as medication concordance.

The principle of non-maleficence is an important injunction against overtreatment, but in reality it is the *weighing up* of beneficence and non-maleficence that determines much of clinical care. Our decision-making therefore needs to be constantly considered within the context of a harm–benefit analysis (Sokol 2013).

Given that the perception of what constitutes a harm and a benefit varies on an individual basis, the principles of non-maleficence and beneficence may best be considered in light of respect for autonomy, one of the four guiding principles of medical ethics. I will explore this a little further, below.

6.5 Considering Ethics as Principlism

Some may question the need to use an ethical framework, but it makes sense to do so in order to help set our own personal codes of moral reasoning aside. They form the basis for expected standards of behaviour. What I may view as right and wrong is relative to another person's view of right and wrong. Our moral codes will likely differ, and it is the use of an ethical framework that enables clinicians to acknowledge the importance of our patients' values and principles. An ethical framework can therefore allow us to appreciate another's values, even if set apart from our own beliefs and moral code (McKinnon 2007).

The four principles plus scope approach to ethical dilemmas offers a culturally neutral and accessible framework (Beauchamp and Childress 2001), and it may be used here to aid thinking about some of the issues that face forensic clinicians when decisions about treatment regimens are being debated. The four principles comprise autonomy, beneficence, non-maleficence and respect for justice. None are seen necessarily in isolation, and conflict commonly arises between them, which allows room for ethical debate as dilemmas arise on a frequent basis.

6.5.1 Autonomy

In Kant's view, patients act with autonomy when they move towards aims and objectives over which they have ownership. This relates to prescribing practice when the patient is able to consider the medication and decide whether they consent to it or refuse it. It also applies to questioning the judgement of the clinician and querying the diagnosis. The degree to which patients in these settings can consent is however a matter for debate. Does consent to medication at times morph into assent? Knowing that an increase in leave (and hence possible increased liberty) is linked closely to your medication concordance is likely to sway your decision to agree to take the medication. Similarly, if you know that your refusal to take oral medication will result in it being forced upon you in injectable form, then you may end up agreeing to take it.

The fact that situations like these arise is due in large part to the nature of the setting. As all forensic patients are detained, legal coercion becomes part of the landscape. The forensic patient finds that their autonomous right to choose between refusing and accepting medication is limited by the treating clinician and team. If the clinician is of the view that the treatment is deemed necessary for the patient's welfare, then it will be enforced, irrespective of the patient's viewpoint. Because the

welfare of others, and society at large, needs also to be born in mind at all times, it is easy to see how further restrictions on one's autonomy can arise. You can see how easy it is for abuses of power to creep in. It is often third parties that influence and determine decisions about treatment and discharge of the forensic patient, and as a consequence, the views of the forensic patient regarding their treatment often bear less weight. Their autonomy is therefore limited.

With respect to autonomy, it could be argued that treatment methods that avoid the use of antipsychotic prescribing altogether may be preferable, for example, individually tailored psychological intervention, or occupational therapy. This avoids much of the ethical dilemma, but if the behaviour is so challenging that engagement with the therapist is futile, then we are again back at the starting blocks. There is no doubt that individual autonomy holds great weight in today's Western society. There is little that challenges the perception that personal success (and therefore power) is of paramount importance. It is interesting to consider however that this perception lies in stark contrast to the way in which non-Western societies operate, where well-being is measured as a collective. In these cultures, the ability of a community to support the health and wealth of its members is seen as its greatest strength. Individualism, and therefore autonomy, has much less importance. The strength in these cultures is in the collective.

6.5.2 Beneficence

This demands that as clinicians we act in a manner to 'seek to do good' to our patients. It is the very meaning of clinical benefit. It can however be difficult to ascertain what beneficence really entails. On the one hand it could be about making the patient feel better on an emotional level, and on the other hand, it could be about making that same patient behave better (often with the aid of medication). And if behaving better is a benefit of treatment, then does this contradict the notion of moral neutrality in medicine, that is, ensuring that we do not impose our own moral values and codes on to anyone else? This ethical dilemma is in turn weighed against the duties that the clinician has to the local community and to wider society. There is the potential here for this to become an ethical minefield.

One important aspect of beneficence is to seek the patient's willingness to accept treatment. Sen et al. have suggested that seeking consent prior to any coercive or enforced medication measure is taken, could be perceived as showing appropriate ethical concern for the patient's beneficence (Sen et al. 2007). The clinical reality however may be somewhat removed from this notion.

In recent years there has been a shift in psychiatry and medicine, away from beneficence and towards autonomy. The shift is towards honesty and authenticity, at the cost of causing potential distress to the patient. Where a clinician may once have withheld some of the truth regarding diagnosis to their patient, believing that it would cause too much distress, the thinking now is that the patient must take the lead in managing their illness, assuming they have the capacity to do so.

6.5.3 Non-maleficence

The use of sedating and powerful medication raises concerns with respect to risk of harm to patients. It is also not clear who should judge the harm suffered. It may be argued that there is merit in short-term breaches of this principle, on the grounds that the longer-term benefits outweigh the short-term distress. It is not always clear however if the harm done to the patient is always in their best interests—at times it is clearly done to meet the needs of the others (for example, the sedative effects of high-dose antipsychotic medication yields the patient less aggressive and therefore the risk of harm to others is reduced). It may also be argued that the loss of physical autonomy that the medication causes is harmful to the patient. What about medication prescribed for the prevention of violence that may happen but has not yet. Is that justified? Can that be construed as doing patients both a wrong and a harm?

6.5.4 Respect for Justice

We are required to treat people in similar ways. However, forensic patients are vulnerable to exploitation and injustice. Political pressure can be exerted in all manner of ways, particularly if the case has a significant media interest. We need to be confident as clinicians that in prescribing these medications, we are acting honestly and fairly, particularly if the medication is strongly opposed by the person receiving it. It is a matter of respect for our patients. It is about keeping in mind respect for their humanity.

6.5.5 Scope of Application of the Principles

The scope of the application relates to the duties of forensic psychiatrists and to third parties and is always a difficult tightrope to walk. The balance is more often than not shifted towards the protection of others.

6.6 Issues with Principlism

Sen et al. have argued that in cases of conflict between different principles, the principle of justice should be given greater credence (Sen et al. 2007). But do we need to consider a moral emphasis? Should we consider, rather, a different approach—one such as the World Medical Association? This method encourages the analysis of rational versus non-rational approaches to ethical decision-making. Rational approaches engage concepts of deontology, utilitarianism, principlism and virtue, whereas non-rational approaches comprise obedience, imitation, feeling or desire, intuition and habit (Williams 2005). There is a case to be made that adopting the principlism approach does not often sit comfortably with forensic psychiatry,

namely, because the principles often lie in conflict with each other but also because there are invariably issues relating to third parties that are not covered by the four principles. Lastly as others have pointed out, in forensic psychiatry there is a need to pay special attention to the principle of justice.

6.7 Informed Consent, Capacity and the Forensic Arena

A competent adult has the right to refuse treatment, even if that refusal of treatment may adversely affect them. It follows therefore that if the patient has capacity, their decision must be respected irrespective of how wise or unwise that decision may be. Lack of capacity may be temporary or it may endure over long periods of time. It may also fluctuate and thus vary. It is the dynamic and situation-specific nature of capacity that can render decision-making difficult. If someone is found lacking capacity, any subsequent decision made regarding their treatment must demonstrate that it was done so in the patient's best interests. It is also important that the methods chosen to deliver the treatment (for example antipsychotic medication) are administered in the least restrictive fashion.

The law dictates that there is a legal duty to obtain informed consent prior to starting treatment. In forensic settings there is a constant tension between care and control and between concepts of capacity and consent. The ethical importance of informed consent is that it is itself key to respecting patient autonomy. The two are inextricably linked together. It is important here to remind ourselves that the essence of autonomy lies with its roots in Kantian reasoning—where the links between autonomy and respect for persons are well established. Put simply, autonomy reflects respect for the person, which is a fundamental principle in the practices of psychiatry.

The legal and ethical foundations of health care are founded on the premise of informed consent, which itself centres on the therapeutic relationship between treating clinician and their patient. It is this patient–doctor relationship that influences the norms of informed consent and it is within the context of this relationship that treatment decisions are made. One of the key elements involved in the process of informed consent comprises information sharing that is accurate and balanced, to include the risks and benefits of not only the proposed treatment but also of the risks and benefits of having no treatment at all. This sharing of information also needs to be sensitive to the values held by the patient, as much as is possible.

Another key element that needs to be held in mind is the assessment of the patient's decision-making capability and, specifically, the ability of the patient to come to an informed, non-coerced decision. It is the remit of the clinician to undertake a clinical judgement of capacity, and this requires careful exploration of a number of factors. These include the ability of the patient to communicate their preferences, to understand and retain the information presented to them, to think through the available choices in a rational manner and to appreciate the nature of the illness and associated recommended treatment in the context of their own life and belief system. This last factor is particularly important, not least because if the

assessment of capacity does not pay consideration to the patient's ability to act in line with an authentic sense of what is right for them, then the resultant consent cannot be considered to be voluntary.

It is interesting to consider the nature of what voluntary cooperation actually comprises. There is in fact a continuum of which numerous shades of voluntarism can be appreciated, such as: active cooperation, passive cooperation, ambivalence, silent objection, irrational opposition and rational refusal. A patient may move along this continuum in either direction during the course of their illness and in the process choose to accept some treatments but not others (Cahn 1982).

In the forensic arena we struggle to obtain voluntarism with respect to informed consent. As adults we are entitled to accept or reject health care interventions on the basis of our own personal values and goals. However, this is not true for those detained against their will. Compare, for example, the psychotic patient in a secure hospital who is quite clearly less able to offer an un-coerced decision than a psychotic patient considering treatment in a community care setting, who can make such a decision. It is evident that it is the context of the situation that either supports or undermines the ability of the patient to come to a truly autonomous decision. Despite the restrictions placed on autonomy, optimal conditions for obtaining informed consent should include an informed psychiatrist, a non-technical presentation, patient familiarity, involvement of other potential informants, information repetition and attempts to ensure that the patient is as free as possible to make the choice without any unreasonable pressure. It is recommended that providing aids to those who may have cognitive impairments should also enhance the process (Applebaum 2007).

Even those that regain the capacity to consent (for example, following the remission of a psychotic episode) find that their capacity to do so is compromised by virtue of the fact that they are unable to refuse the treatment even if they wanted to. As such therefore, although optimal informed consent is considered best practice when consenting a patient to antipsychotic treatment, the process of doing so in a forensic patient is less than perfect. It would appear that the idea of using informed consent to provide assurance that the patient has neither been deceived nor coerced is something that can only really be fully appreciated outside the realm of forensic psychiatry in secure hospital settings.

The legal assumption that patients require capacity in order to be autonomous creates difficulty, not least because many forensic patients are not capacitous for long periods of time. Consider also the fact that for those non-capacitous patients, it is the mental health professionals who become the agents of control (Sen et al. 2007). This does not sit easily with most clinicians. It is further fraught with unease when the primary therapeutic relationship that the forensic patient has is with those that are responsible for the forcible administration of medication. And with the risk associated with enforced medication, the more rigorous the informed consent needs to be. Due to the impact of psychiatric disorders on cognitive functioning, there is, and arguably ought to be, a high degree of scrutiny about issues of capacity to consent to treatment, particularly if the treatment is deemed risky (Carrier et al. 2017).

The refusal to consent (albeit in a compromised manner) to antipsychotic medication whilst detained under mental health law is a common ethical tension that is

played out in forensic settings frequently. To prescribe medication in these situations, the clinician must have confidence that it will be of potential benefit to the individual receiving it. We need to ensure therefore that we have a sound knowledge of the evidence base that supports it and keep the intention of ameliorating the mental illness and contingent behaviours upmost. The ethical principles that guide us help to maintain professional integrity, but in addition to these principles, we might also consider acting in a manner that allows sensitive recognition of what that patient and their family want and then to act sensitively, both admitting and addressing our limits wherever possible (Levine and Bleakley 2012).

We need to ask ourselves whether, in enforcing the medication, we are violating our ethical principles. How do we weigh up our duty to our patient and our duty to the public? Given the arena that we work in, it is our duty to the public (and to third parties) that tends to be more heavily weighted in the decision-making process. We are duty bound to be mindful of our societal contract with the community in terms of attempting to understand, assess and modify risky behaviour in mentally unwell offenders. The use of antipsychotic medication is more often than not central to this endeavour, but we must not lose sight of those we are trying to help whilst also balancing our duty to society. Throughout history we have seen abuses of the privileged clinician–patient relationship and how easy it is for psychopharmacological agents to be harnessed by those in positions of influence to be used as a means by which to advance their own political agendas.

6.8 Conclusion

It is important that as psychiatrists we acknowledge the complexities of human nature and the manifold ways in which mental illness can present. It is equally important to appreciate and make use of the great advances that we have witnessed in recent years with regard to neurobiological understanding of many of these mental processes. As our understanding of mental illness has grown, the development of increasingly sophisticated antipsychotic medication has too. And yet it also remains necessary to acknowledge the limits of our psychiatric understanding.

The use of high-dose antipsychotic treatment regimens tends to be restricted to hospital inpatient units. We know that in not treating the symptoms of mental illness, especially when they are severe and interfere with healthy development and sustenance of emotionally important relationships, there is the potential to be devastating consequences. But, perhaps in light of growing public awareness about mental ill health, there is also a trend for antipsychotic medication to be used as a means by which to manage emotional and behavioural problems in challenging patients outside of hospital too. The use of antipsychotic medication in this way raises the question of whether the idea of drug treatment for behavioural problems is a morally acceptable one. These medications have an important and often necessary role, but there are both ethical and very real dangers associated with these medications, not least those that are prescribed in high doses and in combination.

Michel has argued that the sustained drive to seek out psychopharmacological solutions for the problems of human living constitutes an exemplification of biological reductionism. Although some may disagree with this viewpoint, it is an insight that warrants taking time to pause and reflect (Michel 2011).

With this in mind, at what point do we need to consider issues relating to personhood? What is it to have a meaningful life, alongside its responsibilities and imperfections? Who is it that determines which is held greater—one's dignity and sense of self, or one's improved function and productivity resulting from administration of medication? Some patients feel that treatment with antipsychotic medication has caused their participation in life itself to be deadened and report that their ability to engage with others has become so limited by their pathology that life itself is devoid of meaning. These are treatment decisions that require of the forensic psychiatrist a close and thoughtful ethical analysis at every turn.

It is worth here considering the views of those that oppose the use of antipsychotic medications. There has long been debate about whether these medications are used as chemical alternatives to the straight jacket. The idea that the prescription and administration of antipsychotic medication leads to covert social control encouraged the swelling of the antipsychiatry movement in the 1960s and 1970s. As a consequence, the psychiatric profession reacted by strengthening its medical and scientific credentials, and the idea of the specificity of drug treatment became a central part of that endeavour (Moncrieff 2008). Does psychiatry therefore operate as a covert measure of social control? It is not a question that is to be considered here, but it is not hard to see that as forensic psychiatrists one of the main treatment goals is to achieve behaviour that allows our patients to attain conformity with the law. Many patients however demonstrate behaviours that do not change, despite symptom alleviation, which creates further tension when society has come to expect that the outcome of treatment results in a safer place for all.

Forensic psychiatrists are called upon to practice in a manner that balances competing duties to the individual patient and to wider society. In doing so, we need to be bound by underlying sound ethical principles. We know that informed consent is fundamental to ethical practice because it is the mechanism by which patients autonomously authorise medical interventions. It is this autonomy that allows the patient control over their medical destiny—except that in forensic mental health settings that autonomy is undermined by the nature of the law that detains them. Those detained under mental health law do not have the right to refuse antipsychotic medication if it is deemed by the treating team to be necessary to manage their illness and consequent risks, and thus their autonomous right is undermined by the very legislation that keeps them in hospital.

There is a duty on us to maintain our ethical principles and hold them in mind at all times, not least because this dual relationship to patient and to society can be fraught with challenges. Take, for example, the tendency to prescribe antipsychotic medications to patients based on their previous history of risk alone. This is done in order to reduce the risk of future, potential violence to others. In terms of our ethical commitment to do no harm, can this be justified? Because our patients are guilty of

violent crime, are they less able to claim moral or legal protection? On the other hand, if this patient was undertreated and they committed a violent act against another person, could that less than optimal treatment be justified in the knowledge that they had a history of acting in a violent manner? In a world where the tendency to pathologise and codify human behaviour is becoming increasingly common, it is apparent that the need to adhere to strict ethical code in our daily practice is of the utmost importance.

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