

Involuntary Treatment of Psychosis in Pregnancy

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When a patient with acute psychosis refuses antipsychotic medication despite a clear need for treatment, involuntary medication is often considered. When the patient is both pregnant and acutely unwell, an additional layer of analysis enters the picture. This analysis then also includes the health of the mother and fetus, rights of the mother and fetus, and whose rights take precedence when choosing treatment options in event of a conflict. Antipsychotic agents are frequently the medications prescribed as involuntary treatment. Typical and atypical antipsychotic agents are often used in both emergent and nonemergent situations during pregnancy. Despite a lack of randomized, double-blind, controlled, prospective studies in pregnancy, available data regarding the safety of antipsychotic agents in pregnancy are relatively reassuring. At the same time, the risks of untreated psychosis, for both the mother and the fetus, are not negligible. Such cases merit ethics-related and legal analyses. Forensic psychiatrists involved in such cases need to consider the patient's capacity to make medical decisions and be able to discuss the potential risks, benefits, and alternatives with patients and in court, as part of initiation of involuntary treatment.

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Involuntary treatment with antipsychotic medication most often occurs in the setting of severe mental illness presenting with psychotic symptoms that result in unsafe behavior in patients who do not recognize the need for treatment or the severity of the symptoms they are experiencing. Treatment can become a greater challenge in the subset of individuals experiencing severe psychotic symptoms while they are pregnant, because of concerns over the rights of the individual, the rights of the fetus, the limitations of the treatment literature about risk (e.g., lack of prospective, double-blind studies), and the risks of no treatment (e.g., suicide, harm to others including the fetus, increased social stress, poor follow-up with prenatal care, or risk of substance use relapse). For example, some pregnant women experience psychotic denial of pregnancy, with the delusion that

they are not, in fact, pregnant.^{1,2} Their mental state immediately raises questions about their competency to consent to medical treatment since they may not be able to knowingly and intelligently assess the risks and benefits of treatment.

Mental illness often strikes women during their childbearing years, and initiation of or changes in mental health treatment frequently occur during pregnancy.³ For example, pregnancy can precipitate or exacerbate psychiatric symptoms in some women because of hormone level fluctuations and pregnancy-related pharmacokinetic changes affecting metabolism of medications.⁴ As well, there is a higher proportion of unplanned pregnancies among women with severe mental illness.^{5,6} Women with schizophrenia experience higher rates of unwanted pregnancy and are more likely to experience coercive sexual activity and engage in high-risk sexual behaviors, with unstable relationships, and poorer compliance with contraceptive use when compared with the general population.⁶ In addition, health care providers may underestimate the degree and frequency of sexual activity among patients with severe mental illness, which results in missed opportunities for contraceptive counseling and pregnancy planning.^{6,7}

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Although the older (typical) antipsychotic agents and risperidone may cause hyperprolactinemia and thus decrease fertility rates, other atypical agents generally do not affect fertility.³ Some psychiatrists may neglect to consider this lack of protection from pregnancy when prescribing newer agents to women of childbearing age. Exposure of the fetus to psychotropic medications, before the woman even recognizes that she is pregnant, commonly occurs.

Mental Illness, Pregnancy, and Risk

Mental illness itself, separate from medications, may increase the risk of negative pregnancy outcomes. Schizophrenia has been associated with prematurity, infants who may be large or small for gestational age, and maternal preeclampsia.⁸ As well, more intensive hospital resource use among these women and higher neonatal morbidity are noted.⁸ Many other risk factors are found in this group, particularly the effect of comorbid tobacco, alcohol, or illicit substance use on the fetus.^{9,10} Pregnant women diagnosed with serious mental illness have increased rates of victimization and lesser prenatal care attendance,⁶ each of which, in itself, may increase the risk of negative pregnancy outcomes.

There are significant risks, both to the woman and her fetus, if acute and serious mental illness is untreated. These include the various reasons that mental illness is treated at other times, such as risk of suicide, unintentional self-harm, inability to care for self, increased use of illicit substances, and risk to others (e.g., child abuse and infanticide).¹¹ (Table 1) In pregnancy, poor prenatal care related to the inability to care for self is of concern, and the risk of comorbid substance use takes on even greater meaning.

Rates of major malformations are 2 to 3 percent in the general population,¹¹ and percentages are higher when minor malformations are included. The use of medications complicates this general population finding. Although there is much information about the use of antidepressants and mood stabilizers in pregnancy, there are fewer data about modern (atypical) antipsychotic agents in pregnancy. Despite this, atypical antipsychotic agents are being prescribed with increasing frequency to pregnant women.¹² In general, the older an agent is, the more retrospective data there are, because more women will have inadvertently exposed their pregnancies to medications which have been in use longer. Older atypical antipsychotic agents (including risperidone, olanzapine,

Table 1 Potential Risks of Not Treating Mental Illness in Pregnancy

Suicide
Unintentional self-harm
Infanticide/child abuse
Poor prenatal care, decreased ability to care for self
Increased use of illicit substances
Increased risk of negative outcomes from mental illness, such as low birthweight and prematurity
Effects on bonding with baby

and quetiapine) have been in common use for years for various conditions. The published data about atypical antipsychotic agents are growing at present, and emerging information suggests that they do not increase the risk of malformations in a clinically meaningful way.^{9,13,14} A recent systematic review found infant malformation rates of 3.5 percent for olanzapine, 3.6 percent for quetiapine, and 5.1 percent for risperidone.¹⁵

In addition to infant malformations, the risks of various treatments in pregnancy include fetal loss, prematurity, neonatal syndromes, and neurobehavioral sequelae.^{6,9,11,13,16,17} Table 2 lists these potential risks. Concerns about medication use during pregnancy also carry over into the neonatal period and child brain and nervous system development. Potential risks of psychotropic medications include neonatal toxicity or withdrawal. Toxicity occurs when the infant has been exposed to high levels of a drug that must be metabolized, whereas withdrawal occurs when the infant has become habituated to a drug, and experiences withdrawal symptoms. Both of these conditions, when they occur, are time-limited and usually managed briefly in the neonatal intensive care unit. Research data about the risk of these various negative outcomes are sparser than data about malformations. Neurobehavioral sequelae are more difficult to study because they occur years after fetal exposure.

A full review of specific antipsychotic agents in pregnancy is beyond the scope of this article. How-

Table 2 Potential Risks of Medications in Pregnancy That Physicians Should Consider

Maternal risks
Fetal loss
Prematurity
Malformations
Neonatal syndromes (toxicity or withdrawal)
Neurobehavioral sequelae

ever, the psychiatrist should be aware of the current literature, as well as the specific concerns including treatment throughout pregnancy, avoidance of polypharmacy, and concerns about long-acting injections. In general, treating throughout pregnancy should lead to exposure to a lower total dose of medication because patients who are stabilized on lower doses of medications over a longer period are less likely to require emergently higher doses for acute psychosis.³ Polypharmacy should be minimized in pregnancy because of the potential for a synergistic increase in risk of malformations. Adverse outcomes in pregnancy have been associated with polypharmacy.¹⁰ For example, adding two low-risk medications may have a higher risk than merely the sum of the two. Finally, studies have not often considered the use of long-acting antipsychotic agents in pregnancy. Although the risks may be hypothesized to be similar to medications in their oral formulation, the distribution into the fetal compartment is currently unclear for various depot forms.

Decisions must be case-specific regarding medications in pregnancy. The various risks from the disease state, the individual patient's symptom pattern, and past responses to treatments must be considered. For example, clozapine exposure may increase the risk of maternal gestational diabetes, with attendant infant risks such as large infant size at the time of delivery. However, among women requiring clozapine (e.g., those with treatment-resistant psychosis), recommendations after an individual risk-benefit analysis may include continuation of clozapine throughout pregnancy.³

The concept of absolute versus relative risk is also relevant in the use of medications in pregnancy. For example, classic mood stabilizers, such as lithium and valproate, have a well-known potential for teratogenic effects at specific times in the course of a pregnancy (e.g., in the first trimester, lithium has an elevated risk of Ebstein's anomaly, whereas valproate increases the risk of neural tube defects).¹³ Yet, although occurring at an increased frequency with lithium exposure, Ebstein's anomaly is virtually unknown to psychiatrists outside of lithium use. Even with an increased relative risk with exposure to lithium, the absolute risk of a cardiac defect remains lower than initially believed.^{18,19} Although one decision-maker may find lithium use to be an acceptable risk because this rare cardiovascular defect may be detected on fetal echocardiography or ultrasonogra-

phy and surgically corrected, another may consider lithium too risky. In addition, a fetal defect or termination of pregnancy may place the woman's life at risk. Therefore, the risks that must be assessed when considering involuntary medication of a pregnant woman are unique.

Medical Ethics Considerations in Pregnancy

Perinatal psychiatrists often consider the mother and fetus as a dyad rather than as adversaries.^{16,20,21} When pregnant patients are mentally well, both mothers-to-be (and fathers-to-be) are often included in the discussion about treatment options. Where practicable, this can also occur when the mother-to-be is unwell, such that collaboration may occur within the rest of the family (nuclear or extended).

Ethics principles to consider include: omission versus commission bias, beneficence and relational ethics, autonomy, and preventive ethics.^{16,20,21} Errors of omission (not treating a patient's illness) and errors of commission (if treatment were to lead to a negative outcome) both occur. Doctors are often more concerned about making errors of commission, which lead to a bias toward making errors of omission.^{16,20,21} To many physicians, failure to treat is seen as preferable to a risk of infant malformation. Although many physicians worry about the potential risk of lawsuits if medications lead to malformations, it is important to consider that failure to treat may create serious risk for suicides and homicides, which may also lead to lawsuits.

Beneficence, promoting the patient's best interest, often intersects with the fetus' best interest.¹⁶ Miller noted that "the patient's well-being and her baby's well-being are intertwined, rather than at odds" (Ref. 21, p 260). Beneficence, then, would often include using antipsychotic agents in situations severe enough to trigger an involuntary medication evaluation.

In pregnancy, a patient's decision-making is tied to that patient's perception of risk.¹⁷ Autonomy may be increased by clearly explaining the risk of treatment in pregnancy to the patient in absolute risk rather than relative risk terms. For example, a drug may increase the risk that an adverse event will occur from 0.1 percent to 0.4 percent. The relative risk would be four times higher, but the absolute risk is still less than 0.5 percent. Patients (as well as physicians) often overestimate the risk of malformations.

Efforts to enhance a sense of autonomy should be made during the course of treatment, given that regaining capacity and autonomy is an ultimate goal.

Preventative ethics include the anticipation of the dilemmas of treatment in pregnancy, and thus engaging in planning.^{16,21} Discussions of the possibility of pregnancy should be held in advance, along with discussions about medications and illness.

Some argue strongly against the use of medication in pregnancy, because of misunderstandings of the aforementioned concerns. Misinterpretations of relative versus absolute risk cause fears of exaggerated rates of bad outcomes. Thinking that fetal well-being is the only concern while not understanding the interrelated nature of mother and infant well-being leads to limited decision-making. Refusing treatment may endanger the fetus, because of maternal suicide risk or fetal risk from untreated illness. Harm to the mother leads to harm to the fetus and vice versa.

Involuntary Medications for Vulnerable Populations

Evaluation of competence to make medical decisions in pregnancy, as at other times in life, is meant to protect vulnerable patients' health from their own irrational decisions.²² A proper balance occurs between this protection of those with impaired decision-making and respecting the autonomy of competent patients.²³ Competency to make medical decisions includes appreciation of diagnosis and consequences, understanding relevant information, rational manipulation of this information, and ability to communicate a choice.^{23,24}

Historically involuntary treatment referred to the judicial authorization of antipsychotic treatment in hospitalized mentally ill patients who lacked capacity to make medical decisions. Today, there are significant jurisdictional differences regarding authorization of involuntary antipsychotic treatment in the community. Regardless of the setting, the decision-making regarding involuntary treatment involves a careful risk–benefit analysis including an appreciation of the risks inherent in vulnerable populations. For example, involuntary antipsychotic treatment in elderly patients with dementia includes consideration of FDA warnings regarding the risk of stroke and sudden death.²⁵ Despite these warnings, the use of antipsychotic agents in older patients is common because there are limited alternatives for the treat-

ment of psychosis.²⁶ Similar to the case in pregnant women, antipsychotic treatment in the elderly has a higher risk of medical comorbidity and thereby warrants a thoughtful risk–benefit analysis. Other high-risk patient populations include medically compromised patients with diabetes, obesity, and hyperlipidemia. Treatment with atypical antipsychotics may increase the risk of metabolic syndrome and diabetes.²⁷ Again, the decision to treat medically vulnerable patients, such as pregnant women, involuntarily with antipsychotic agents should be informed by a weighing of risks and benefits for this specialized population.

The prescription of involuntary antipsychotic treatment in pregnancy, although unique in some aspects, has similarities to other vulnerable patient populations, such as the elderly and the medically compromised. In each of these populations, the decision about involuntary treatment considers the indication for treatment, the appropriateness of treatment (empirical evidence), and a risk–benefit analysis for the specific patient.

Legal Aspects of Forced Treatment in Pregnancy

As aforementioned, involuntary treatment cases during pregnancy also involve the rights of the fetus. In conceptualizing this concern, the growing body of law regarding civil commitment for substance use during pregnancy²⁸ is relevant to the discussion of involuntary treatment of psychosis in pregnancy.

Concern over effects of maternal prenatal substance use (prescribed or otherwise) started to obtain public attention in the 1960s and 1970s because of the birth defects attributed to thalidomide, cancer attributed to diethylstilbestrol (DES), and the recognition of fetal alcohol syndrome.²⁹ In the 1980s, concerns over the crack cocaine epidemic and infant withdrawal effects further called attention to the harm a mother's prenatal behavior could have on her child after birth.²⁹ In the 2000s, prescription opioid and methamphetamine abuse continued to fuel the public's concern.

Fetal rights have been legislated for decades and have been closely tied to the "personhood of the fetus" movement.³⁰ Various jurisdictions have tried to use the notion of fetal rights to reduce substance use during pregnancy by leveraging the threat of criminal action or civil commitment if voluntary treatment was not obtained.^{28–32} To further complicate the

medical and family problems involved with perinatal substance use, many have seen the expansion of fetal-rights laws (e.g., criminal statutes that increased penalties if harming a pregnant woman and her fetus, and feticide laws) in general as a way to undermine *Roe v. Wade* and a woman's right to choose.^{30,32} Many in the medical and public arena express concern that forced treatments for substance use may prioritize fetal rights over the woman's rights, and potentially lead to a slippery slope when it comes to other decisions that a pregnant woman can make (such as C-sections, diets, or elective termination).^{29,30,33} The political and social factors surrounding these problems often have implications far exceeding the usual civil rights and due process concerns that arise in most involuntary treatment cases.

Involuntary substance use treatment follows similar decision-making as involuntary antipsychotic medication in the weighing of benefits against harms; but what is defined as a harm and whose benefit takes precedence? There are clearly some situations in which both the fetus' and mother's lives are at equal risk of harm. However, in most situations, the fetal life is at greater risk, given its developing state, than the life of the mother, who is physiologically more robust. For example, few people die of opioid withdrawal but the physiologic effects of withdrawal lead to a greater risk of pregnancy complications, miscarriage, and preterm labor.³⁴ In addition, there are conflicting opinions on appropriate medication dosages. As a treatment, low-dose methadone may prevent withdrawal and be safer for the fetus, but may not fully address aspects of the woman's substance use disorder, such as optimal reduction of cravings.²⁹ This decision becomes one of risk versus benefit where reasonable clinicians can come to differing conclusions on a case-by-case basis as to what approach is best for both mother and fetus (e.g., low dose is best because it is best for the infant and reduces some effects for mother, versus high dose is best, because, if the mother relapses, then both fetus and mother are at risk).

As the forced substance abuse treatment debate highlights, forensic psychiatrists involved in forensic evaluations during pregnancy often have to weigh more factors than one would in a standard treatment assessment. Given the complexity and medicolegal aspects of pregnancy, forensic psychiatrists perform various evaluations during pregnancy, including involuntary treatment and capacity to consent to ter-

mination.^{22,35} Psychiatrists may have to be prepared to address larger social concerns, stigma, and preconceived notions regarding a treatment decision when it affects a pregnant woman and her fetus. Involuntary treatment evaluations during pregnancy involve potential disagreements among the treatment team (when personal beliefs and biases are brought in, with different priorities on whose health comes first), more family involvement and possible disagreement, and increased legal, political, and social pressures from various sources. Therefore, it is imperative when engaging in these evaluations to maintain a clear focus on the specific question at hand and not get distracted by the myriad side matters.

Medical Decision-Making Recommendations

Medication decisions in pregnancy are complex, and it is important for the psychiatrist to give the patient sufficient information. A mentally well person who does not understand probabilities, who overvalues the ($n = 1$) experiences of family or friends, or who has overvalued ideas about a physician may not make a logical decision.³⁶ Although the goal is to support autonomy such that a competent patient can make the decision, patients who cannot rationally manipulate the appropriately balanced information may not be competent to make this decision.

Pregnant women experiencing psychosis who refuse medication may not be competent to make such treatment decisions and antipsychotic medications may be sought as involuntary treatment during preg-

Table 3 Suggestions for Completion of Evaluation for Involuntary Treatment in Pregnancy

Start with standard forensic approach for forced treatment
Know the law in your jurisdiction (<i>Rennie or Rogers model</i>) ^{37,38}
Diagnosis
Rationale for need for treatment
Reason capacity is lacking
Determining less restrictive alternatives
Knowledge of literature on fetal and pregnancy complications
Clearly identify harms of no treatment in report; others may focus only on medication harms or may be ignorant of the risks of not treating
Communication with other medical staff (e.g. obstetrics and pediatrics), since risk is outside usual area of forensic expertise
Clearly understand trimesters (for example, the point at which the fetus becomes viable, the medications that may pose a risk during different trimesters/weeks, and the length of time bed-rest needed)

nancy. The evaluating forensic psychiatrist should begin with a standard forensic approach regarding forced treatment²³ (Table 3). An appropriate evaluation should include diagnosis, rationale regarding the need for treatment, and evaluation of capacity. State and jurisdictional laws (e.g., the *Rogers v. Commissioner of Department of Mental Health* or *Rennie v. Klein* model^{37,38}), disagreement about severity of the illness, and disagreement about risks and benefits of treatment all affect the use of involuntary psychotropic medication.

Appropriate assessment in these cases also includes understanding on the part of the forensic psychiatrist of the risks of lack of treatment, as discussed above. The harms of failure to treat should be specifically described, because others involved in the process may not understand the full impact of no treatment. It is important to refresh one's knowledge and understanding of the literature regarding medications in pregnancy and effects on the fetus. Consultation and communication with other medical staff involved in the woman's treatment can be critical as well, including her obstetrician and the pediatrician who will be caring for the infant. Obstetricians and neonatologists deal with risks in pregnancy daily, whereas psychiatrists usually do not. There is anecdotal evidence that discussions with obstetricians and pediatricians can be beneficial in forming the psychiatrist's opinion and treatment recommendations about forced medications. Obstetricians and pediatricians can also help with continuing education of the patient when she regains competency.

When a pregnant woman's illness grossly impairs her ability to make autonomous decisions, depending on the jurisdiction, either the "substituted-judgment" or "best-interest" test will be used. For example, if the best-interest test is used, the decision-maker will need to understand the risks and benefits of both treated and untreated mental illness. However, a substituted-judgment analysis would consider the value the mother would put on the fetus' safety and health. In some cases, a guardian-ad-litem (GAL) may be appointed for the fetus.²¹ However, the GAL role of considering the fetus' best interest may yield a separate analysis from the mother's best interest, despite the two being inter-related.

If feasible, for involuntary medication orders in pregnancy, oral medications or possibly short-acting injectable antipsychotics are preferred over long-acting injections. In addition, oral medications give

more dosage flexibility than long-acting injections do. Despite the widely variable commitment laws, it is foreseeable that in most civil commitment and forced treatment evaluations involving forensic psychiatrists, treatment would occur in a controlled environment (e.g., a psychiatric hospital), which implies better monitoring and long-term compliance, negating some of the usual treatment concerns leading to the use of long-acting injectable antipsychotics.

Finally, some pregnant women may actually want to take medications, but refuse because of fears based on media reporting of relative risk or based on attorney advertisements. Some may be (secretly) glad the judge has ordered injections and then may be agreeable to taking oral medications.

Conclusions

When it comes to determining the capacity for involuntary treatment, the standard forensic questions involve a risk–benefit analysis. However, when the patient is pregnant, quantifying the risks becomes more complex. Risks and benefits of treatment should be weighed against the risks of untreated mental illness. It is critical that one keep a perspective about the risks of untreated illness, for both the patient and fetus. These evaluations require forensic psychiatrists to consider their own biases and potential biases or fears of others involved in the process (members of the treatment team, the family, and the legal system). Others involved in the process may require education about what the literature reveals about the risks. In addition, psychiatrists should focus much greater attention on the harms of lack of treatment than would occur with other forced treatment examinations. As with any forensic evaluation, objectivity should be sought, and the potential for distraction by matters outside the questions that apply to the individual case in question should be minimized.

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