Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Descriptive Study of the New York Experience with Judicial Review

Brian Ladds, M.D., Antonio Convit, M.D., Julie Zito, Ph.D., and Joseph Vitrai, Ph.D.

The United States Supreme Court, in the recent case of *Riggins v. Nevada*, extended its examination of the issue of involuntary treatment with antipsychotic medication to the mentally disabled facing criminal trial. A criminal defendant who is "incompetent to stand trial" cannot be subjected to trial. Many such persons are committed to hospitals to be treated and rendered "competent to stand trial," and some of these patients refuse medication. The involuntary administration of antipsychotic medication to such patients raises important and unique medical and moral questions. This highly controversial issue has been understudied. We report here on the first study of persons committed to a state hospital in order to be rendered competent to stand trial who refuse antipsychotic medication and for whom judicial review is requested to allow involuntary treatment, and in which results are given specifically for these subjects. This is a retrospective study to determine the characteristics of such cases and aspects of their outcome in the hospital. We reviewed all cases (N = 68) of application for treatment over objection, filed since the inception in 1986 of the new laws and regulations requiring judicial review through 1990, among patients in the two facilities that receive over 95 percent of all indicted felony offenders in New York State who are incompetent to stand trial. Tentative conclusions are formulated based on the findings that, according to clinician reports, no patient gave only rational reasons for medication refusal, clinicians always indicated the clinical appropriateness of the proposed treatment, judges apparently never found that someone who is "incompetent to stand trial" is "competent" to refuse medication, 93 percent of patients treated involuntarily had a good clinical response, and 87 percent of patients treated involuntarily were restored to "competency to stand trial."

The United States Supreme Court, in the recent case of *Riggins v. Nevada*,[1] expanded its examination of the issue of involuntary treatment with antipsychotic medication, and called attention to the dearth of empirical data on many important aspects of this subject. The issue of involuntary administration of antipsychotic medication arises in a variety of contexts. One of the most im-

Address correspondence to Dr. Ladds, 201-2J West 92nd St., New York, NY 10025.

An earlier version of this paper was presented at the Annual Meeting of the American Academy of Psychiatry and the Law, October 1992 and won the 1993 A.A.P.L. Award for Best Research by a Fellow in Forensic Psychiatry.

portant settings involves mentally disabled individuals facing criminal trial. This situation entails matters of life and death where the death penalty applies, as it does in the majority of states.

As the Supreme Court stated in *Dusky v. U.S.*,[2] and identified as a Constitutional requirement in *Pate v. Robinson*,[3] for a criminal trial to proceed the criminal defendant must possess "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and . . . rational as well as factual understanding of the proceedings against him." Individuals who meet this test are said to be "competent to stand trial." Many criminal defendants are too psychiatrically impaired to be considered "competent to stand trial."[4]

The Supreme Court in *Jackson v. Indiana*[5] indicated that criminal defendants who are not "competent to stand trial" may be committed to a psychiatric hospital for the restoration of their competency to stand trial, after which they may be subjected to their pending criminal trial. This restoration is commonly achieved through the administration of antipsychotic medication.

There is much commentary in the legal literature,[6-18] and many cases among lower courts,[19-21] concerning criminal defendants who refuse such treatment. However, the psychiatric literature on the treatment of "incompetent to stand trial" defendants is more sparse,[22-30] and several studies do not address the role of medication at all.[31-36] As we later note, there are even fewer empirical studies that focus specifically upon the involuntary administration of antipsychotic medication to criminal defendants who have been adjudicated as "incompetent to stand trial."

The lack of empirical knowledge on this subject was commented on by the Supreme Court in the case of *Riggins v. Nevada*. That case dealt with a criminal defendant who was forced to continue on antipsychotic medication during his criminal trial. The jury convicted Riggins and sentenced him to death. On appeal, he argued that being forced to take antipsychotic medication interfered, in a variety of ways, with his rights to a fair trial. The Court in its majority opinion reversed Riggins' conviction on procedural grounds. It held that the forced administration of antipsychotic medication during Riggins' criminal trial, without a sufficient determination by the lower court on the matter, violated his Constitutional rights, including both his Sixth Amendment right to counsel and his Fourteenth Amendment rights to due process.

The majority opinion stated in passing, "Although we have not had occasion to develop substantive standards for judging forced administration of such drugs in the trial or pretrial settings, Nevada certainly would have satisfied due process if . . . [the local court] had found that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others. Similarly, the State might have been able to justify medically appropriate, involuntary treatment with the drug by estab-

lishing that it could not obtain an adjudication of Riggins' guilt or innocence by using less intrusive means. . . ." Importantly, the Court added, "The question of whether a competent criminal defendant may refuse antipsychotic medication if cessation of medication would render him incompetent at trial is not before us." The Court also stated, "We have no occasion to finally prescribe such substantive standards as mentioned above." The majority opinion, in other words, was restricting its holding to a narrow procedural matter.

Justice Kennedy in his concurring opinion in the *Riggins* case, commented on the "Courts failure to address . . . [the substantive] issues . . ." and added his "reservations about the propriety of involuntary medication for the purpose of rendering the defendant competent, and to explain what I think ought to express qualifications of the Court's opinion. . . ." Justice Kennedy stated that:

> . . . the whole subject of treating incompetence to stand trial by drug medication is somewhat new to the law, if not to medicine. . . . I file this separate opinion . . . to express my view that the [Constitution] prohibits . . . involuntary . . . antipsychotic medicines for purposes of rendering the accused competent for trial absent an extraordinary showing, and to express my doubt that the showing can be made, given our present understanding of the properties of these drugs. . . .
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> Here the purpose of the medication is not merely to treat . . . but rather to render the person competent to stand trial. . . . [The State must in every case make] a showing that there is no significant risk that the medication will impair or alter in any material way the defendant's capacity or willingness to react . . . at trial. . . . Based on my understanding of the medical literature, I have substantial reservations that the State can make that showing. Indeed, the inquiry itself is elusive, for it assumes some baseline of normality that experts may have some difficulty in establishing for a particular defendant, if they can establish it at all.

Justice Kennedy emphasizes many possible side effects that antipsychotic medications may have on a defendant. He states that this includes a variety of effects that can alter a defendant's "demeanor in a manner that will prejudice his reactions and presentation in the courtroom . . ." and render him "unable or unwilling to assist counsel." Justice Kennedy further speaks of sedation, and a "'sedation-like effect' that in severe cases may affect thought processes." He writes that, "The side effects . . . can hamper the attorney-client relation, preventing effective communication and rendering the defendant less able or willing to take part in his defense. The State interferes with this relation when it administers a drug to dull cognition."

He states that, "In my view medication of the type here prescribed may be for the very purpose of imposing constraints on the defendant's own will, and for that reason its legitimacy is put in grave doubt. If the State cannot render the defendant competent without involuntary medication, then it must resort to civil commitment. . . . The state of our knowledge of antipsychotic drugs and their side effects is evolving . . . we can permit their use only when the State can show that involuntary treatment does not cause alterations raising the concerns enumerated in this separate opinion." It would seem almost impos-

sible that Justice Kennedy's strict criteria for involuntary medication could be met. This separate opinion of Justice Kennedy may be influential to lower courts and, at the very least, it suggests that there is a need for more empirical data to illuminate the many questions raised by the involuntary restoration of competency to stand trial.

The handful of empirical studies that have looked specifically at the involuntary medication of persons who have been adjudged "incompetent to stand trial" are limited in the scope of their inquiry, the methodology they employ, or in their lack of outcome measures. Several studies of patients in forensic facilities who refuse medication, for example, simply do not include persons who have been adjudged "incompetent to stand trial" at all.[37–39] Other related studies do not select subjects on the basis of this particular legal status. Thus, several of these studies may include some patients who are "incompetent to stand trial," but whether this is the case is either not mentioned, or, the results of the studies are not given in relation to this specific legal status.[40–44]

In articles derived from one group of forensic facility patients,[45–47] a subgroup of patients committed as "incompetent to stand trial" was identified. About one-third of these patients were referred to as medication "refusers" and one-half of these refusers received "involuntary" medication. These studies, however, are not directly applicable to the situation of "incompetent to stand trial" defendants that Justice Kennedy refers to in the *Riggins* decision. These studies define "involuntary treatment" as the medication given to any patient who refused medication and who "posed an imminent serious physical threat to themselves or others." Thus, "involuntary treatment" in those studies includes treatment administered on an *emergency* basis. As the Supreme Court indicated in *Washington v. Harper* (see especially the dissent; 48), emergency treatment is an issue that is often entirely distinguishable from the issues involved in the involuntary administration of medication in situations that are not clinical emergencies.

The study by Young *et al.*[49] did include patients who had been adjudged "incompetent to stand trial" and who refused medication. This study describes the experience of treatment refusal by 17 patients who were incompetent to stand trial who underwent the administrative review required by Oregon state law.

However, in many jurisdictions, such as New York since the 1986 decision of *Rivers v. Katz*,[50] the decision to override any patient's refusal of treatment involves judicial review (see also for example, 51). Indeed, the dicta of the majority opinion in *Riggins v. Nevada* implies that judicial review of some sort may be uniquely required in the decision to override the medication refusal of a person who is "incompetent to stand trial," at least if that person is to be on medication during his criminal trial. The Court faults the lower trial court in Nevada for not having made a "determination" or "finding" that there was a need for forcing medication upon the

defendant during his criminal trial. The Court's analysis could be extended by lower courts to require judicial permission to involuntarily medicate incompetent criminal defendants who are in a hospital prior to trial, even in jurisdictions that do not require judicial review for the medication refusal of civil patients.

A study of judicial review of the treatment refusal by "incompetent to stand trial" defendants therefore seems important. Such a study could provide data that may have relevance to the numerous ethical, legal, and clinical issues that are related to the considerations leading clinicians to apply for, and judges to decide about involuntary treatment at such hearings. Even in jurisdictions where judicial hearings have not been required, these hearings may be uniquely suitable to evaluate the balance of effects that involuntary medication may have on the criminal defendant both clinically and with respect to the disposition of the pending criminal charges. An empirical study of aspects of this process may reveal the way it actually operates and highlight some of its complexities. A literature review reveals no study of this kind, with results given specifically for such a group of patients.

Study Aims

We report here on the first study of persons committed to a state hospital for the restoration of their "competency to stand trial" who refuse antipsychotic medication and for whom the request to treat involuntarily is scheduled for judicial review, and in which results are given specifically for this group of subjects.

This study aims to determine various characteristics and the intermediate outcome in the hospital of this special group of medication refusers. Questions asked include: How frequently are applications to the court made to involuntarily medicate patients who are committed for restoration of their "competency to stand trial"? What are the sociodemographic and diagnostic features of this group? Additional questions that we aim to address include: What factors influence clinicians to seek treatment over objection with such patients; is it to treat the patient for his current clinical needs, to restore "competency to stand trial," or both? Likewise, what factors are relevant to judicial decision-making on these matters?

This study will explore the proportion of applications to the court for involuntary treatment that result in judicial orders granting the application. We will also investigate the reasons for any judicial denial of such applications. We will also seek to address whether involuntary treatment is successful clinically and in restoring competency to stand trial, and how long this process takes.

Methods

For a number of reasons, we considered it most useful to limit our inquiry to subjects who met several criteria. First, the individuals must have been adjudicated as "incompetent to stand trial" and committed to a hospital for

the restoration of trial competency. More specifically, we limited our sample to defendants with serious charges, namely felonies, who were also indicted by a grand jury on those charges, and were therefore likely to be brought to trial. These defendants are committed to a hospital pursuant to New York State Criminal Procedure Law (C.P.L.) section 730.50. In New York, misdemeanor offenders who are found incompetent to stand trial have their charges dismissed, and felony offenders who have not been indicted can be criminally committed for a brief period of time beyond which their charges must be dismissed.

The second criterion for inclusion in this study is refusal of antipsychotic medication. We define "refusal" narrowly to include only those persons whose refusal of treatment has led their clinicians to file an application for a judicial review in order to gain a court order to treat the patient over his objection. Judicial review to override a patient's refusal of medication has been required in New York State since the *Rivers v. Katz*[50] decision of 1986. These hearings determine the patient's capacity to make decisions, and the "best interests" of the patient. Patients who refuse medication long enough to lead to this final stage of review, and who are not presenting acute clinical emergencies at the time of the review process, pose some of the most controversial and important questions pertaining to "the right to refuse medication," especially, as we have noted, with persons who are "incompetent to stand trial." This study therefore is specifically designed to examine only a small subset of incompetent felony offenders who refuse medication. Some information for this study was obtained from the application forms filed by clinicians and the clinical director in all state hospitals in New York, in accordance with the Office of Mental Health regulations that followed the 1986 *Rivers v. Katz* decision.

The period under study begins with the inception of these regulations. We therefore aimed to include all C.P.L. 730.50 patients for whom an application for treatment over objection was filed between July 1986 and December 31, 1990. In this four and one half year study period, over 95 percent of all incompetent to stand trial indicted felony offenders in all of New York State were admitted to one of two maximum security forensic facilities: Kirby or Mid-Hudson Forensic Psychiatric Center (personal communication, 52). We therefore limited out inquiry to these two facilities. About three-quarters of all such patients had only one admission in the study period, 15 percent had two admissions, and about seven percent had more than two admissions.

The design of the study is a retrospective review of both the hospital charts and also the "treatment over objection" application forms. These applications have been described and used in previous studies.[53–55] One of the facilities used only one application form per patient. In the other facility, a second application form was completed, usually by the clinical director. In this study, we examined only those forms completed by clinicians or forensic fellows and ex-

cluded the forms filled out by the clinical director, who is a hospital administrator.

The reasons recorded on the forms for medication refusal were defined as "rational" or "irrational" in the same way as in previous studies.[54, 55] Temporally distinct repeat cases of applications for the same patient are counted separately. Provisions to ensure against breach of confidentiality were observed. Both the institutional review board and the state Office of Mental Health approved this study.

The time between admission and the filing of the application for involuntary treatment is termed "time to application," and the time between the application and the court hearing for those cases that received such judicial review is termed "time to review." A "good clinical response" is defined as the consensus view of the interdisciplinary treatment team as recorded in the chart. "Restoration" to "competency to stand trial" is defined as the assessment on this issue of the clinicians who do not have clinical responsibilities for the patient and who are not involved in the application to treat the patient over objection. At the time of this study, in one facility this group was made up of an interdisciplinary panel, and in the other facility it is made up of two psychiatrists alone.

Statistical analyses included chi-square tests for categorical variables and *t*-tests for continuous variables.

Results

In all, there were 68 cases of applications to involuntarily medicate "incompetent to stand trial" indicted felony offenders in the four and a half year study period. When clinicians specified the antipsychotic medications that they wished to administer, it often included long-acting fluphenazine or haloperidol, which must be given intramuscularly.

The 68 cases arose in a group of 61 patients. Of the 61 patients, 54 refused treatment once and seven refused on two separate occasions. Of the seven patients who refused medication twice, four were the subject of two applications for involuntary treatment during one continuous hospitalization, and three had cases of repeat refusal during a subsequent hospitalization. The results reported below generally pertain to the 68 *cases*, but information is given in relation to the 61 *persons* in the study where this is relevant.

Table 1 shown below indicates sociodemographic and some clinical characteristics of the 68 cases in this group. Almost two-thirds of the cases came from one of the facilities. However, statistical analysis using S.P.S.S. (56) revealed no significant difference between facilities with respect to the sociodemographic or other variables. The average age was 40.

Although almost 10 percent of all admissions to these two facilities involving "incompetent to stand trial" indicted felony offenders were female,[52] there was only one female among the refusing patients in this study. Results for the individual unduplicated *persons* of this study are roughly the same as that shown for all of the "*cases*" of refusal. The majority of unduplicated *persons* were single (66%), black (54%, with 31%

white and 13% Hispanic), and 64 percent of *persons* had a prior history of psychiatric hospitalizations, and 88 percent had a history of past criminal arrests. It should be noted, however, that some of the past arrests were minor.

All subjects by definition had the same legal status. One case, however, was unusual in that it involved a retrospective evaluation of "competency to stand trial" for a trial that had already taken place. This case is included because the trial court also instructed the hospital to evaluate this defendant's current "competency to stand trial" for the retrial that would be necessary if he was retrospectively found to have been incompetent during his past trial.

Table 2, below, displays the DSM-III-R diagnoses of this group. All but two had a primary diagnosis of a psychotic disorder, most of which were schizophrenia. More than a quarter of the patients were also given a dual diagnosis of

Table 1
Characteristics of Cases (N = 68)

Variable	Description	Number (%)
Facility	Kirby	24 (35)
	Mid-Hudson	44 (65)
Age	Years	40
Gender	Male	67 (99)
	Female	1 (1)
Marital status (of persons)	Single	40 (66)
	Married	21 (34)
Ethnicity (of persons)	White	19 (31)
	Black	33 (54)
	Hispanic	8 (13)
	Other	1 (2)
Legal status	CPL 730.50	68 (100)
Education	H.S. Graduate	35 (51)
	Not-H.S. Graduate	29 (43)
	Missing	4 (6)
Psychiatric history	Yes	45 (66)
	No	20 (31)
	Missing	3 (4)
Prior criminal history	Yes	54 (79)
	No	8 (12)
	Missing	6 (9)

Table 2
Diagnoses of Cases (N = 68)

DSM-III-R Axis	Description	Number (%)
Axis I	Psychotic disorder	67 (96)
	Mood disorder, psychotic	1 (1.5)
	With Substance Abuse	19 (28)
Axis II	Antisocial PD	9 (13)
	Other PD	8 (12)
	Deferred/missing	51 (75)
Axis III	Yes	25 (37)
	No	43 (63)

substance abuse. Clinicians generally did not indicate a diagnosis of personality disorder on the application forms. Although in over a third of cases some medical problem was noted, these were generally minor.

Table 3, below, displays for each person involved in at least one case of treatment refusal the primary criminal charge for which the defendant was initially indicted. Over 80 percent of crimes were violent, but several, such as the sale of drugs, were not.

Table 3
Initial Criminal Charges of Patients (N = 61)

Charge	Number of cases
Murder	14
Attempted murder	8
Assault	12
Kidnapping	1
Reckless endangerment	1
Burglary or attempted	10
Grand larceny	1
Robbery or attempted	7
Arson or attempted	3
Sexual abuse	1
Criminal possession of weapon	1
Criminal sale of controlled substance	2
Total	61

Table 4, below, shows the motivation of the treating clinicians, to the extent that this is reflected in the application forms submitted to the court for involuntary treatment. In no case was the patient reported to articulate a rational reason as the only reason for medication refusal.

A statistically significant difference between facilities was noted with respect to the reasons reported by clinicians for the patients' refusal. One facility indicated no cases in which the patient included a rational reason for refusal, whereas in the other facility on over half of the forms a rational reason for refusal was included. Despite the first facility's reports that patients gave no rational reasons for refusal, five of the six cases of applications for involuntary treatment that were denied by the courts (see below) came from that facility. The difference in proportions of applications granted between the two facilities, however, was not statistically significant.

The application forms also contain a section concerning dangerousness, even though dangerousness *per se* is not a

Table 4
Motivations/Dangerousness from Petition Applications

Variable	Description	Number
Reason refuses	Rational reason alone	0
	Irrational reason alone	44
	Both	11
	Missing	13
Potential benefits	Clinical goal	13
	Legal goal	0
	Both	43
	Missing	12
Dangerousness	To self/others	40
	Not	2
	Blank	14
	Missing	12

required criterion in the review process outlined in *Rivers v. Katz.* In 14 of the complete forms that were found, this section was blank. In 40 forms clinicians indicated that they considered the patient dangerous to self or others.

Table 5 shows some intermediate outcome measures for these 68 cases. As noted, there was a lengthy period between admission to the application for involuntary treatment. Fifteen cases did not receive court review. This was generally because the patient consented to treatment after the application to the court was made, which obviated a court hearing. There was on average a lengthy period of hospitalization before the applications for involuntary medication were filed. For those cases that were reviewed (almost 80% of all applications), there was an additional month and a half delay, on average, from the time of the application until the actual hearing. Judges granted the request for involuntary treatment in 89 percent of the cases that had hearings. In one case, despite judicial permission to medicate the patient involuntarily, he improved and was found competent to stand trial without ever actually having received any medication.

Judges generally did not modify the clinician's request as written on the applications. In seven cases the judge permitted involuntary treatment for a period less than what had been requested by the clinicians. In one case the judge granted the patient the choice of either oral or intramuscular route of medication administration, though only the latter was requested by the clinician.

Table 5 also indicates that in 93 percent of the 46 cases in which medication was involuntarily given, an unequivocally good clinical response was noted. In the majority of such cases the response was described as rapid and robust and "dramatic." In addition to this clin-

Table 5
Intermediate Outcome Measures of Cases of Refusal (N = 68)

Variable	Description	Outcome (%)
Time to application	Days	124
Court review	Yes	53 (78)
	No	15 (22)
Time to review	Days	48
Permission granted of cases reviewed	Yes	47 (89)
	No	6 (11)
Modified by judge	Yes	8 (17)
	No	39 (83)
Clinical response to involuntary medication	Good	42 (93)
	Limited or no response	3 (7)
	Missing	1
Restored to fitness	Yes	39 (87)
	No	6 (13)
	Death	1
Length of hospitalization for discharged cases	Days	278

ical response, in about 87 percent of the 45 cases in which involuntary medication was given (excluding one case in which death preceded an adequate trial of medication) there was restoration to "competency to stand trial." The total length of hospitalization, for the entire group of patients who were discharged by the end of the study period, was about nine months. As noted below, six patients were still in the hospital at the end of the study period (and these patients were excluded in determining the average length of hospitalization).

In five cases the judge at the hearing regarding involuntary medication denied the request for involuntary treatment. In one additional case the application was dismissed on a motion by the patient's lawyer on the procedural grounds that the lawyer had not received appropriate advance notice. This patient was the subject of another application for involuntary treatment three months later, and this second time the application was granted. In four other cases the judge indicated that in his view the patient was "competent to stand trial" in the unmedicated state.

Finally, in one case the judge denied the application for reasons that are not fully clear. (The chart recorded that the judge ordered, that in the event of a reapplication, the patient should be examined by psychiatric examiners who were "non-Semitic" since the patient was anti-Semitic.) One and a half months later such a reapplication was indeed made. The patient insisted on representing himself at the hearing, lost, was treated involuntarily, improved, became "competent to stand trial," and was discharged.

Discussion

The implications of the results of this study on some of the issues that emerge with the involuntary treatment of incompetent defendants will be addressed in the following sections.

1. Are Incompetent Defendants Competent to Refuse Treatment? In many jurisdictions, such as in New York under *Rivers*, the legal analysis required to override a medication refusal begins with a determination of the refusing patient's decision-making "capacity" (or "competency"). Questions can be raised about the application of this process to the case of the "incompetent to stand trial" defendant.

This type of patient is after all admitted to the hospital already adjudicated as "incompetent," albeit for a separate function. How meaningful is it to inquire further about these patients' "competency" to make decisions? Of course, it is in theory possible that "competencies" in these two areas of functioning are distinct and unrelated. This is especially arguable in light of the *Rivers* court's intentional avoidance of defining what decision-making capacity means. Nonetheless, we must ask whether the *Rivers* decision was ever intended to, or should, apply to the unique category of patients who have been adjudicated to have failed a clear test of what usually depends on rational thinking and rational interpersonal relating.

Moreover, the indicted felony defendant who is adjudicated as "incompetent

to stand trial" is involuntarily committed by the court for the express purpose of treatment to restore trial competency. This is in contrast to all other patients who may be committed in New York only if they are a danger to themselves or others. Both of these danger-related concerns can indeed often be addressed by the commitment into the hospital *per se*, without the administration of the clinically indicated medication. The *Rivers* procedural inquiry therefore readily makes sense for civilly committed patients. With the incompetent defendant, on the other hand, it seems possible to ask whether the usual *Rivers* analysis should apply.

The results of this study seem to support the idea that many trial court judges answer this question in the negative. Despite the commonly accepted notion that incompetence for one specific function does not imply incompetence for a different function, the results of this study suggest that in practice this theoretical distinction is not always persuasive. In the four and one-half years of *Rivers* hearings involving "incompetent to stand trial" indicted felony offenders, there is not one single clear case in which a judge found a patient to continue to be "incompetent to stand trial" and at the same time "competent" to refuse treatment. In the few cases in which the judges denied the application for involuntary treatment, it was because they also found, at the same hearing, that the patient was fit to stand trial in the unmedicated state. (In passing, it may be noted that it appears that these judges showed a lower threshold for, and were more ready to find a patient restored to, "competency to stand trial," than were the forensic clinicians who were closely involved with the patient.)

This general lack of a finding of decision-making capacity among incompetent defendants is not surprising given several other results about the patients and the proposed treatment in this study. These patients generally had severe psychiatric disorders. According to the clinician reports, these patients also did not cite concerns about side effects as the only reason for their refusal of medication. (These persistent reasons for refusal may be in contrast to the reasons for refusal that obtain in the more transient refusals identified by some authors[58] in the civil setting.) Clinicians also always reported that treatment was clinically indicated. These factors may explain why these incompetent defendants were deemed incompetent to refuse medication.

We may also note in passing, that clinician application for, and the resulting judicial approval of, involuntary medication of the patients in this study may have been partly related to the perceived dangerousness of these patients. The possible importance of perceived dangerousness may be supported by the inclusion on the application forms in the majority of cases indications affirming the patient's potential for dangerous behavior, even though this is not an explicitly required element in the *Rivers* calculus for overriding treatment refusal. Since, as seen, clinicians report being motivated primarily to meet the clinical needs of the patient, it may be that dan-

gerousness is viewed as stemming from the underlying clinical condition. Concerns about dangerousness may therefore, at least in part, relate to concerns about the patient's clinical welfare.

2. Is Involuntary Treatment Effective? Several writers have speculated that involuntary medication treatment of incompetent defendants would not be effective. Wexler and Winick,[59] for example, have written, "Based upon the literature on the psychology of choice ... it can be hypothesized that the potential for successful treatments of defendants who are incompetent to stand trial increases when the defendant accepts treatment voluntarily, rather than as a result of court coercion, typically involving an incompetency commitment to a forensic facility."

Though the data from this study do not disprove this view they do strongly suggest that involuntary treatment is highly efficacious in improving trial-incompetent defendants both clinically and functionally. This is consistent with the findings of Young *et al.*[49]

The data from this study likewise suggest that some of Justice Kennedy's blanket pessimism and emphasis on the medications' potential to "impair" the defendant does not fully correspond to the empirical experience of the overall effects of these medications on the subjects in this study while they are in the hospital prior to trial. While Justice Kennedy's concerns about side effects focus primarily on their impact upon an actual criminal trial, it remains noteworthy that in the view of those experts who evaluate the force-medicated patients, in over 87 percent of cases the patients regain their ability to understand the criminal charges and assist counsel. In short, the defendants are improved.

3. Should Judicial Review Be Used? The rate of judicial override of patients' medication refusal in this study, 89 percent, indicates that judges in this study generally but not always grant the clinicians applications for forced medication. The rate in this study is lower than the 100 percent judicial override found in the study by Miller *et al.*,[42] but that study is not directly comparable because it included an unspecified number of patients who were being evaluated for, as opposed to having been already adjudicated as, "incompetent to stand trial." The rate found in the present study may be most aptly compared to the 97 percent rate of override found by Young *et al.*,[49] in his study of the administrative review process of 17 "incompetent to stand trial" patients.

Administrative review did resolve the treatment standoff more rapidly, with an average of nine days delay rather than the 48 days which the present study showed was required, on average, to obtain judicial review. Despite these additional costs, however, and contrary to the view espoused by Miller *et al.*,[42] judicial review might very well be justified precisely because of the lower rate of override and the ethical and legal complexities involved in involuntary medication of this unique population.

4. How Common Is Medication Refusal Among the IST? The results of this study allow for an estimation of the

subset of medication refusals that lead clinicians to request court permission for involuntary treatment, among patients in New York State who are under indictment for a felony and are incompetent to stand trial. For purposes of this calculation, we exclude the one case of refusal that occurred during the six-month period immediately following the implementation of the new regulations requiring judicial review. In the remaining four-year period of the study, there were 67 cases of such persistent medication refusal arising among 60 persons. The number of incompetent to stand trial felony offenders whose medication refusal leads to an application for formal review is thus approximately 15 per year in New York State.

In this same period, there were on average 272.6 incompetent to stand trial indicted felony offenders committed each year to the facilities under study.[52] Within this specially defined group of incompetent offenders, the annual proportion of patients whose refusal leads to applications for judicial review is 5.4 percent (the ratio of 15 to 272.6). Not surprisingly, these numbers and rates are less than those found by Young *et al.*[49] among a more heterogeneous and broader group of incompetent offenders, or by Rodenhauser *et al.*[45–47] who considered even transient refusal.

Limitations and Further Research

This study has the same limitations that inhere to any descriptive study. Without statistical analyses making comparisons to reference groups, no firm conclusions can be drawn. It would be most meaningful to compare IST refusers to an unduplicated group of nonrefusing "incompetent to stand trial" patients, who are also matched with respect to severity of illness and to criminal charge. Data from such reference groups are not yet fully available to us for such work.

Limitations of this study also flow from its retrospective nature and its use of the information on application forms. Some information on a clinicians' application to the court could conceivably say as much about the clinicians' legal strategy as it does about the clinical status of the patient. This issue is underscored by the statistically significant disparity noted above between the two facilities regarding clinician reports of the reasons given by the patient for medication refusal.

A prospective study that would specify in advance ways to assess such factors as reasons for refusal, assessments of dangerousness, and clinician's motivations would have obvious advantages. Given the low occurrence of persistent refusal in this select group of patients, however, a prospective study could take years to complete and would be very costly.

One final type of limitation of this study may be illustrated by our measurement of the intermediate outcome of involuntary treatment. We considered clinical outcome and restoration of trial competency in the general and global manner in which these concepts were commonly defined and used in practice in the pre-*Riggins* era. It is possible that the many specific concerns evoked by Justice Kennedy, when he referred to

the need to show, "... that there is no significant risk that the medication will impair or alter in any material way the defendant's capacity or willingness to react ... at trial ..." will remain vital pieces of missing information as it relates to an actual criminal trial. Justice Kennedy's "reservations" about the side effects of these medications are of course especially critical in relation to trials where the death penalty is at stake.

Conclusive statements about the effects of involuntary medication on "incompetent to stand trial" defendants also require research studies that determine the effects of the medication upon the final adjudication of the pending criminal charges. We report elsewhere[60] on the ultimate outcome and final disposition of the criminal charges of the subjects from this study.

Thus, future research on the issues that we have attempted to address empirically here could extend the analyses in several ways. Until such data are available some tentative conclusions could be drawn from the data of this study.

Conclusions

1. Though there may be rational reasons for incompetent defendants to refuse treatment with antipsychotic medications these are not the sole reasons provided by the great majority of such patients in this study, according to clinician's records.

2. Clinicians indicate on application forms that they are not motivated to treat defendants involuntarily merely to meet the needs of the criminal justice system to return defendants to trial, but always also by the patient's clinical needs.

3. Clinicians also indicate that concerns about the refusing patient's dangerousness often call for involuntary medication.

4. Both clinicians and judges find the great majority of people who are *incompetent* to stand trial and who persistently refuse medication to also be *incompetent* to refuse it.

5. Both clinicians and judges in this study similarly found involuntary medication to be in the "best interests" of the patient.

6. Involuntary treatment with antipsychotic medication often works dramatically to both clinically improve the great majority of such patients and to restore their competency to stand trial, using global clinical assessments while the patient is still in the hospital.

7. Judicial denial of involuntary treatment is not infrequently followed by judicial approval when reapplication is sought.

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