

Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Review of Empirical Studies

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Involuntary administration of antipsychotic medication to pretrial criminal defendants raises important and controversial questions. These questions arise especially with defendants who have been adjudicated as incompetent to stand trial and who require medication to be restored to trial-competency and return to face their pending criminal charges. This subject has been fiercely debated for decades, but it has received little empirical investigation. We review here the known empirical studies that have looked at the use of involuntary medication for this population of individuals. The following nine conceptual areas are explored: subject selection, definition of 'refusal' and related terms, frequency of refusal, characteristics of refusers, reasons for treatment, reasons for refusal, type and outcome of the review of the refusal, outcome of treatment in the hospital, and outcome of the criminal charges. Relevant findings are reviewed. Methodological limitations call for more research in this area.

Involuntary administration of antipsychotic medication to pretrial criminal defendants raises important and controversial questions. These questions arise especially with defendants who have been adjudicated as incompetent to stand trial and who require such medication to be restored to trial-competency

and to then face their pending criminal charges. Should such individuals have a special "right to refuse" medication because of the possible adverse effects that the medication could conceivably have on their pending criminal case?

This subject has been fiercely debated for decades in the legal literature,¹⁻⁹ but it has received little empirical investigation. This lack of empirical information was commented on by the United States Supreme Court in the recent case of *Riggins v. Nevada*.¹⁰ Together with our associates, we have previously reported¹¹ on a descriptive study of incompetent criminal defendants in New York State

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for whom court permission was requested to involuntarily administer antipsychotic medication. We have also reported¹² on the disposition of the pending criminal charges of these involuntarily medicated defendants. Those reports made mention of several other closely related empirical studies but did not review them in detail, nor did they emphasize the specific methodological issues that attend such studies.

We review here in greater detail the known empirical studies that have investigated the use of involuntary medication with this population of individuals. A literature review using the Medline and Psychlit databases revealed only a handful of empirical studies on this subject. On one level the paucity of research in this area is understandable. There are after all relatively few people in this category compared to the general population of psychiatric patients who refuse medication. Nonetheless, given the medical and moral dilemmas that uniquely arise with such a population of persons, an analysis of the little empirical data that is available seems important. We follow here the conceptual framework used by Appelbaum and Hoge¹³ in their review of the research on the general "right to refuse" antipsychotic medication. We use their approach and several of the categories that they have delineated, as well as several others, to focus specifically on issues that pertain to criminal defendants who are incompetent to stand trial and who refuse medication. The following nine conceptual areas are explored: subject selection,

definition of "refusal" and related terms, frequency of refusal, characteristics of refusers, reasons for treatment, reasons for refusal, type and outcome of the review of the refusal, outcome of treatment in the hospital, and outcome of the criminal charges.

Subject Selection

As we turn to the empirical studies, we find several methodological problems that limit the interpretation or generalizability of the relevant reported findings. Several problems pertain to the selection of patients who make up the subjects of a given study. First, we are not aware of any published reports on the effects of involuntary medication on a defendant at the time of an actual criminal trial. Research to date has focused primarily on the defendant who is force-medicated in the pretrial phase and specifically on such persons while they are committed to a forensic hospital, as opposed to those receiving treatment while detained in jail.

The report by Veliz¹⁴ is an example of a study of the "right to refuse" medication in a forensic facility in which the patients' legal status receives little formal attention. The authors enumerate a variety of categories of patients in the forensic facility in which the study takes place, including patients under civil as well as criminal commitment. Surprisingly, Veliz *et al.* make no mention of any persons committed to that facility for the purpose of restoration of competency to stand trial. We may surmise, however, that there were such incompetent to stand trial defendants in the

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facility because a large proportion of admissions were for pretrial evaluations of competence, some of whom were presumably found incompetent. They do not, however, specify the legal status of any of the patients who were actually included in their particular study of medication refusal.

Other studies make it clear that they include patients who are incompetent to stand trial and who refuse medication, but they do not provide results specifically for such a narrowly defined group. The study by Miller *et al.*,¹⁵ for example, examines in aggregate patients committed to the hospital for very different reasons. In reporting the results of their study, they do not provide data specifically for those persons already adjudged incompetent to stand trial who were committed for the restoration of such competency. Instead, data for that group are provided in combination with the related data for the group of persons committed for an *evaluation* of competency to stand trial. This study, therefore, provides information about forensic patients who refuse medication in general, but not specifically about persons committed to a hospital having already been found incompetent to stand trial.

The study by Deland¹⁶ likewise takes place in a forensic facility, but there is no mention of the specific legal status of the 18 cases in which a petition was filed requesting permission for involuntary treatment with medication. Since the authors state that the great majority of patients in this facility were sentenced prisoners, it is likely that the majority of

the 18 cases of medication refusal arose as well among sentenced prisoners, as opposed to patients committed with the legal status of "incompetent to stand trial". This study, then, is not directly relevant to medication refusal among incompetent defendants. The study by Sauvayre¹⁷ likewise reports its results without specifically distinguishing between the particular legal status of the patients studied.

There are other methodological limitations with these studies. They are limited to one facility, and make no mention of the relative proportion of persons incompetent to stand trial who have been committed to other facilities in the state. This may limit the generalizability of the findings. Most studies of incompetent to stand trial medication refusers are also limited to study periods that are brief in duration. As the study by Miller indicates, this design may make a study prone to the artifactual effects of the events of a given period of time, such as new legislation or case law. Finally, the studies mentioned combine defendants facing widely disparate criminal charges. This may make it difficult to discern findings particular to a more homogeneous subset of criminal defendants.

In our report,¹¹ we attempted to circumvent some of these limitations, by studying the two facilities in New York State that receive more than 95% of defendants committed for the restoration of trial-competency, over a 4 and one-half year period. The sample was restricted 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. Further studies with similarly narrow criteria for subject selection, and which then follow the defendants through the actual criminal trial, may be most informative for the type of questions raised indirectly in *Riggins*.

Definition of Refusal, Involuntary Treatment, and Medication

Additional methodological problems pertain to the way in which concepts such as *refusal*, *involuntary treatment*, and *medication* are defined in the research studies. The main focus of the controversy regarding involuntary medication among defendants who are incompetent to stand trial pertains to those patients who refuse precisely the treatment that can restore them to competency to stand trial. In other words, the critical issues here are not those involving transient refusal, or the administration of medication as "emergency restraints" to an acutely violent patient. Instead, what is important is the process of formal review of the clinician's request to override a patient's persistent refusal of medication. Because there are few empirical studies of this subject, the closely related studies by Rodenhauser¹⁸⁻²⁰ and Veliz¹⁴ will also be commented upon where relevant.

Rodenhauser studied a group of patients in a forensic facility¹⁸⁻²⁰ and in one article²⁰ identified a sub-group of patients committed as "incompetent to stand trial." Approximately one-third of these patients were referred to as medication "refusers" and one-half of these refusers received "involuntary" medica-

tion. As we have pointed out,¹¹ however, these studies are not directly applicable to the situation of persons who are "incompetent to stand trial" who refuse the ongoing medication that would restore them to trial-competency. Rodenhauser *et al.* define "refuser" as any patient who persists in nonacceptance of medication for one week, or less if a patient is considered dangerous. In addition, "involuntary treatment" is defined as the medication given to any patient who refused medication and who "posed an imminent serious physical threat to themselves or others." Thus, these studies included instances in which medication was administered involuntarily on a temporary *emergency* basis. These studies are thus not designed to specifically investigate the persistent refusal that leads clinicians to formally seek permission for ongoing nonemergency involuntary treatment of even nondangerous patients. Indeed, the studies by Rodenhauser *et al.* do not mention any formal mechanism for either the review of the patients' refusals or to allow ongoing involuntary treatment for the patients under study. The studies by Rodenhauser also do not define which "medication" is being administered. Since numerous medications may be used as "emergency restraints," medication in these studies could refer to medications other than anti-psychotic medications.

In some jurisdictions, patients who "assent" to treatment but who are unable to formally give informed consent are afforded the same legal safeguards as patients who refuse medication. The study by Veliz¹⁴ takes place in one such

jurisdiction. In reporting their results, they combine patients who refuse medication with those who "assent" to treatment. There are, however, important differences between these two sets of circumstances. Lumping them together limits the interpretation of a study's findings and its applicability to other contexts. As noted earlier, they also combine patients with diverse legal categories in their data analysis.

As we have noted, and attempted to follow in our study,¹¹ we feel that the most informative designs should specify *antipsychotic* medication, and operationally define "refusal" as the persistent refusal of treatment leading clinicians to seek the formal mechanism of review required in that jurisdiction before non-emergency "involuntary treatment" can be administered.

It should also be noted in passing that the forcible administration of other forms of psychiatric treatment also raise profound questions in the pretrial setting. Forced electroconvulsive therapy, for example, is highly controversial and its use in the pre-trial context has been the subject of one recent empirical study.²¹ That study found that forced electroconvulsive therapy of a pre-trial criminal defendant did occur in New York State during the period of 1986 to 1990. Although only one such case out of more than 1,300 incompetent patients was noted in that report, numerous clinical, ethical, and legal issues arose with that case. Recommendations are suggested in that article for ways to address some of these issues in the future.

Frequency of Refusal

One of the concerns that has emerged with the application of the right to refuse treatment to the setting of pretrial criminal defendants is that criminal defendants might opt to refuse treatment in order to avoid being brought to criminal trial. To assess how important this concern might be, it would be useful to know how many mentally disabled criminal defendants require antipsychotic medication in order to become or remain competent to stand trial. It would be especially useful to know the frequency of medication refusal among this group of mentally disabled criminal offenders who are at risk for becoming or remaining incompetent to stand trial without medication.

The empirical research studies shed some light on this matter. As we have noted, the studies by Rodenhauser are only indirectly applicable, as they included even persons whose refusal was transient. We would expect a higher frequency for this broadly defined group of refusers than we would for the smaller group of patients whose refusal prompts clinicians to pursue formal mechanisms to override their refusal.

The studies by Rodenhauser *et al.* found the rates for what we might call the "transient refusal" among persons who are incompetent to stand trial to be 31.4 percent. This is higher than the rate he found for similarly defined "refusal" among patients admitted for forensic evaluations, 25 percent, but it is about the same rate as that among insanity acquittees, 31.7 percent, and lower than the rate of refusal among civilly com-

mitted patients in the same forensic facility, who had a refusal rate of 48.3 percent. It should be noted that Rodenhauser *et al.* do not define what they mean by the term "refusal rate." The denominator in this term might refer to the total number of patients with a given legal status, or it might refer only to the number of such patients who are prescribed medication. If the latter is intended, then the rate of refusal would be even higher if it was calculated just for those *at risk*, i.e., those prescribed medication. This question of how *refusal rate* might be defined emerges as well by noting that in the study by Miller, refusal rate seems to be defined differently than by Rodenhauser. Miller seems to define it as the ratio of *refusers to those people who were prescribed medication*, and he does not provide a rate specifically for incompetent defendants.

The study by Young *et al.*²² included 17 patients who had been adjudged incompetent to stand trial and who refused anti-psychotic medication, during the 9-month study period, leading to formal review. Extrapolated to a yearly rate, this represents a rate of 22.6 incompetent defendants who persistently refuse medication and lead clinicians to request an override each year in the state hospital under study. Since the authors do not state the number of yearly admissions of persons who are incompetent to stand trial, the incidence of refusals among such persons cannot be determined. The authors also do not indicate whether the other two state hospitals in Oregon accept such patients. Assuming they do not, we may infer that in a given year

Oregon has about 23 incompetent defendants whose refusal of antipsychotic medication leads to formal review. The ways in which one might evaluate this finding might depend on such factors as the nature of the original criminal offense and the consequences of upholding the defendant's refusal. The specific criminal charges of the defendants are not enumerated in Young's report, and it is therefore difficult to evaluate its findings in this regard. As we note below, it may be inferred that the group under study by Young included even defendants who faced only misdemeanor charges.

We reported¹¹ on the rate of those refusals that led to review, among criminal defendants who were under indictment for a felony and who were incompetent to stand trial in New York State. For purposes of this calculation, we excluded a case of refusal that occurred during the six-month period immediately following the implementation of the new regulations requiring judicial review of medication refusal in New York State. In the remaining four-year period of the study, there were 67 cases of medication refusal arising among 60 persons. The number of incompetent to stand trial felony offenders whose medication refusal leads to application for formal review is thus approximately 15 per year in New York State. In this same period, we noted that there were on average 272.6 incompetent to stand trial indicted felony offenders committed each year to the facilities under study. Within this specially defined group of incompetent offenders, we noted that

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the annual ratio of patients whose refusal leads to applications for judicial review is 5.4 percent (the ratio of 15 to 272.6). Since we investigated only persons who are incompetent to stand trial who are charged with a felony and who are under indictment, it is not surprising that the number of persistent refusers leading to review in this select category is smaller than the number of persistent refusers in the Oregon study by Young, which defined incompetent offenders in broader terms.

In order to evaluate the magnitude of these numbers, we must recall that they represent patients who refuse medication despite the near inevitability that their refusal will be overturned, as we note below. If, as Justice Kennedy in the *Riggins* case¹⁰ would have it, medication refusal were to be especially upheld among patients who are incompetent to stand trial, we might expect the number of persistent refusals to rise significantly.

Characteristics of Treatment Refusers

Some effort has been made to determine the characteristics of incompetent defendants who refuse medication, leading to formal review. These identified characteristics are generally not placed into a meaningful context by comparisons to control groups. Without making such comparisons to groups of, for example, incompetent to stand trial medication acceptors, it is difficult to learn what distinguishes these refusers from the nonrefusers or from refusers who have a different legal status. In investigating the characteristics of such medi-

cation-refusing incompetent to stand trial defendants, both *clinical* variables and *demographic* variables are relevant, as is the nature of the *criminal charge*. There is little empirical data in any of these areas.

In the study by Young *et al.*²² in Oregon, the characteristics of the incompetent defendants are reported only in aggregate with the other group of forensic refusers in their study, the insanity acquittees. Although they state that the characteristics of these two groups are "very similar," they do not specify what they mean by this, and this lack of specificity makes the applicability of their findings to incompetent defendants unclear. However, given the limited research available in this area, it is worth noting their aggregate findings as it may constitute some reflection of the typical characteristics of incompetent refusers. They found that the typical forensic refuser in their study was a relatively young unemployed white male, who lived alone or with his nuclear family, carried a diagnosis of schizophrenia, and had a history of previous psychiatric admissions, and in a third of the cases also carried an additional diagnosis of substance abuse. Young *et al.* do not specifically provide information about the relevant criminal charges for patients who are incompetent to stand trial. As already noted, however, we may infer from the overall data they provide that the charges faced by the group of incompetent to stand trial refusers whom they studied included a wide range of crimes including misdemeanors, such as harassment.

Our study¹¹ in New York found that the majority of patients were single males, more than half were black, the overall average age was 40, most had a prior history of psychiatric hospitalizations, and almost 90 percent had past arrests. It should be noted, however, that almost a third had no psychiatric history and some of the past arrests were minor. Although almost 10 percent of all admissions of incompetent to stand trial defendants to the two facilities studied were female, there was only one female found among the 60 patients whose refusal led to an application for override of the refusal. All but one of these 60 refusers had a primary diagnosis of a psychotic disorder, mainly Schizophrenia. More than a quarter of the patients were also given a dual diagnosis of Substance Abuse. Although for over a third some medical problem was noted, these were generally minor. More than 80% of the refusers were initially indicted for violent crimes, but several involved non-violent felonies, such as the sale of drugs.

The data from these various studies suggest that incompetent defendants who persistently refuse medication leading to a formal request to override the refusal may differ in racial makeup in different geographic areas, but share the presence of severe psychiatric disorders. This is relevant to the next issue: the reasons for proposed involuntary treatment.

Reasons for Treatment

Ordinarily, clinicians seek to treat patients for clinical reasons. In the case of incompetent defendants who refuse

medication, an additional possible motivation might exist to seek involuntary treatment. This involves furthering the state interest of returning the patient, who is also a criminal offender with charges pending, to the courts for the criminal trial. The research reveals some empirical information on the question of clinician motivation.

Young²² reports that clinicians gave, on average, two reasons for their request to treat a patient over objection. They report a variety of clinically oriented reasons to seek involuntary treatment, such as that the mental status of a patient was not improving (71% of cases) or the patient's condition was deteriorating (35%) or the occurrence of physical attacks (41%). They do not report whether any of the clinicians connected the need for treatment to the particular goal of restoring competency to stand trial and returning the defendant to trial.

In our report,¹¹ we noted the motivation of the treating clinicians, to the extent that this is reflected in the application forms submitted to the court for involuntary treatment. We found that in no case did the clinician cite the legal goal of restoration to trial-competency as the sole reason to treat the patient with the requested medication. In 13 of 56 (23%) cases, the clinician cited only clinical reasons to treat the patient involuntarily, and in 43 of 56 cases (77%), both the clinical goal and the legal goal were cited. We have noted a limitation with information deriving from clinicians' applications to the court for involuntary treatment; it could conceivably say as much about a clinician's legal

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strategy in seeking permission for involuntary treatment as it does about a patient's clinical status.

We must also note that in criminal cases that involve the possibility of a death sentence, restoring competency to stand trial may arguably be in the interests of society, but may not be in the interests of the criminal defendant. None of the empirical data from the studies mentioned here has any direct bearing on cases involving the death penalty. Empirical studies of such cases need to be done. In the meantime, the data summarized here, concerning the presence of severe mental illness and the purported clinical need for treatment, seem to lend some support to the clinical appropriateness of proposed forced treatment of pretrial incompetent defendants, in non-death penalty cases. If in fact such treatment is appropriate, it is natural to inquire about the reasons for its refusal.

Reasons for Refusal

Unique reasons to refuse antipsychotic medication have been asserted on behalf of patients who are incompetent to stand trial.¹⁻⁹ What do the research studies reveal about the actual reasons that these particular patients put forth to refuse medication?

Young²² reports data on six pretrial patients. Two (or 33% of these six patients) denied having any mental illness and consequently any need for medication. Two complained of anticipated or present side effects, although Young does not report whether these patients connected any of their expressed con-

cerns about side effects to the impact such effects might have on a potential upcoming criminal trial. Finally, one patient was delusional about the medication, and one made comments that were "indecipherable."

In our study¹¹ it was found that, according to clinician reports, in no case did the patient articulate a rational reason as the only reason for medication refusal. A statistically significant difference between the two facilities under study 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 filed to gain authorization for forced medication, a rational reason for refusal was acknowledged by the clinician. This interfacility difference may suggest that the information recorded on such forms may be partly colored by clinician's attitudes. Nonetheless, the limited empirical data seem to suggest that patient refusal very frequently contains an irrational basis.

Type and Outcome of Review of Refusal

A patient's medication refusal can be reviewed and overruled through two basic mechanisms; administrative or judicial review.²³ Different criteria for overriding refusal are also in use in different jurisdictions. Empirical studies reveal some information about the type and outcome of the review process for treatment refusals among incompetent

defendants. We have commented briefly on this in our previous reports.¹¹⁻¹²

In the study by Young,²² administrative review involving the chief medical officer or director of the hospital, in consultation with an independent physician, was used. In Oregon, treatment may be given if "good cause" is found to exist, although this is not defined in their article. There is no mention of any need to consider the decision-making capacity of the patient. Young found that the 16 incompetent defendants spent on average nine days between their refusal and its override through administrative review. Young reports that in one case the chief medical officer declined to override a patient's refusal, but he does not state whether this patient was an incompetent defendant. (This one patient received another evaluation one month later, and the refusal was at that time overridden.) We may infer therefore that the rate of administrative override of refusal among incompetent defendants was no less than 16/17 (94%) and possibly 100 percent.

In the jurisdiction under study by Veliz, the decisions concerning involuntary treatment are made by a judge who first must make a finding about the patient's competency to make treatment decisions. In the second step in the process of reviewing a patient's refusal, the judge uses "substituted judgement," based on a host of considerations, to determine whether the patient should receive medication. Although as stated above, it is unclear whether the Veliz study includes incompetent defendants, it is interesting to note that Veliz found

that whenever the judge determined that a patient was lacking in competence to make decisions, the "substituted judgement" made by the judge was that if the patient was competent, the patient would choose to accept the medication. One other finding by Veliz of relevance here was the finding that courts seemed to rely on reports of the patient's violence in arriving at decisions about involuntary treatment, even though this is not a criterion explicitly provided for in applicable laws in that jurisdiction.

In many jurisdictions such as New York, since the 1986 decision of *Rivers v. Katz*,²⁴ the decision to override any patient's refusal of medication involves judicial review. We have also previously suggested¹¹ that the dicta of the majority opinion in *Riggins v. Nevada* may imply 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 a criminal trial. Studies of judicial review of the treatment refusal by "incompetent to stand trial" defendants are therefore especially important.

The study by Miller¹⁵ involved judicial review of 39 medication refusers. All cases receiving a hearing resulted in a judicial ruling permitting treatment over objection. It is interesting to note that the study recorded combining the very first hearing regarding whether the defendant is competent to stand trial with a hearing to determine whether he is competent to refuse medication. They argue that judicial review is unnecessary and wastes time, although as we have

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previously suggested,¹¹ this opinion does not necessarily follow from their data. They also noted that no patient who had a refusal judicially overturned was any more willing to actually receive the medication than he or she had been previously.

In our report¹¹ on the results of the judicial review process used in New York, we found, first, a lengthy period of time between admission to the hospital and the filing of the application for involuntary treatment, and an additional month and a half delay, on average, from the time of the application until the actual court hearing. By the time a hearing was available, 14 of the 68 applications were withdrawn, generally because the patient had by that time consented to treatment. Judges granted the request for involuntary treatment in 87 percent of the cases that had hearings and they generally did not modify the clinician's requests in substantial ways. There were several cases in which the judge denied involuntary treatment because the judge found that the defendant was competent to stand trial in the unmedicated state.

It therefore appears that when incompetent defendants persistently refuse medication and clinicians seek permission for forced treatment, permission is generally granted, whether the decision makers are doctors, administrators, or judges. The limited data suggest that judicial review involves greater delays than does administrative review. Both of these findings are similar to what has been found in research of the "right to refuse" among other populations of psy-

chiatric patients.²³ As we have previously suggested, however, unique issues that pertain to the refusal of incompetent defendants may make judicial review especially suitable, if not necessary, for its resolution.

Outcome of Treatment and Charges

In order to properly evaluate the implications of the "right to refuse" treatment among incompetent defendants, it is important to study the effects of allowing this right to be asserted and the effects of overriding it. The patients who assert this right are affected in numerous ways, as are other patients and staff who are on the same hospital ward. Effects of the overall process that merit empirical study include whether behaviors such as assaults occur while awaiting review of medication refusal, what the patient's clinical response to involuntary treatment is, and whether it succeeds in restoring competency to stand trial. The outcome measure regarding involuntary treatment with antipsychotic medication that is unique and perhaps most important to the pretrial criminal defendant is the eventual effect of such treatment on the ultimate disposition of pending criminal charges.

Outcome of Treatment in the Hospital Young (22) found that 3 of 16 (19%) incompetent defendants required and received emergency medication. In four of the five times emergency medication was given, this took place while the patient was asserting the "right to refuse." Only one instance of emergency treatment took place after the re-

fusal was overridden. Twelve of 16 (75%) of the incompetent defendants were placed in seclusion on a total of 64 occasions, with the majority (56%) occurring after the refusal was overridden. Five of 16 (31%) incompetent to stand trial patients were placed in restraints for a total of seven episodes, of which 57% occurred before the refusal was overridden. The authors do not explain why a large proportion of incidents of seclusion and restraints took place after involuntary treatment was instituted.

Young found that the group of incompetent defendants whose persistent refusal was contested by clinicians spent an average of 56 days in the hospital. Of special importance, they report that "almost all patients improved significantly by discharge. . ." Though the authors did not define what is meant by 'improvement,' they do state that all (100%) patients who were incompetent to stand trial were restored to competency to stand trial after involuntary medication.

Rodenhauser¹⁸⁻²⁰ found that in general "refusers were restored to fitness more frequently (72.4%) than nonrefusers (49.2%)." This would suggest that at least transient refusal could reflect some characteristic that predicted good outcome. However, it is important to note that they also found that there "is no significant difference in success rates between those who were medicated involuntarily and those who were medicated voluntarily."

We reported¹¹ that of those persons ultimately medicated involuntarily, 93 percent demonstrated a good clinical response as defined by the documented

global impression of a member of the treatment team. In the majority of such cases the response was described as rapid or "dramatic." In addition to this clinical response, about 87% of the involuntarily treated patients were restored to competency to stand trial. The total length of hospitalization, for the entire group of patients who were discharged by the end of that study period, was approximately nine months.

Outcome of Criminal Trial Perhaps the most important issue regarding involuntary treatment of a criminal defendant is the ultimate disposition of the pending criminal charges. The study that we reported with our associates¹² is the only one we are aware of on this subject. We reported on the outcome of the criminal charges for all 61 persons from our earlier study. All patients were followed for a minimum of six months after the end of the study period. Of the 61 patients, 43 were medicated involuntarily; in the other cases the applications were withdrawn, judicially denied, or the patient did not receive involuntary treatment for another reason.

There were 35 cases of involuntarily treated incompetent defendants that had a known disposition of their criminal charges, not counting the one case of death. Of these cases, 28 (80%) were convicted, all but four through plea negotiation, and the majority of these defendants were sentenced to prison. Only five involuntarily medicated defendants actually had a criminal trial, which resulted in four convictions and one insanity acquittal. In two cases of involuntarily medicated defendants, charges were

dropped following a "Jackson" proceeding; in which the defendant was found to be permanently incompetent. In that study, it was not known whether patients remained on medication at trial. That study suggested that in non-death-penalty cases, force-medicating defendants to trial-competency does not necessarily prevent an insanity acquittal, and it also allows plea negotiation to proceed.

Conclusions

In conclusion, surprisingly little empirical research has been conducted in this important area of psychiatry and the law. Additional empirical studies could be very helpful in providing factual data that might help resolve legal and ethical quandaries inherent in the forced restoration of trial-competency.

Such studies should select subjects and interventions in a carefully defined way. We suggest further research of non-emergency treatment using anti-psychotic medications of indicted felony offenders. This is the group most likely to go to trial, and they therefore lend themselves to longitudinal study. The ideal empirical research design to answer the many questions of fact that arise in the involuntary treatment of persons who are incompetent to stand trial would be prospective. It would specify in advance ways to assess such factors as reasons for refusal, and a clinician's motivations to seek forced treatment, and the method that will be used to assess the overall effects of forced medication at an actual criminal trial. The outcome in these cases would then be compared with cases involving defendants who are similar in

all respects, except for not receiving involuntary medication at trial.

The retrospective studies reviewed here provide the only empirical information available in this area at this time. Several of the relevant studies are informative but suffer from being generally comprised of small numbers of patients, lacking relevant control groups, and lacking a study of important outcome measures. Our own studies in this area have attempted to circumvent some of these limitations, but lack adequate control groups and do not provide direct data relevant to death penalty cases or to the actual effects of involuntary medication at a criminal trial.

With the above limitations acknowledged, this review of empirical studies suggests to us that the existing data lend some support to the following claims about the involuntary treatment of incompetent to stand trial defendants with anti-psychotic medication in non-death-penalty cases. These patients generally suffer from severe psychiatric disorders; clinicians propose treatment primarily for a variety of clinically based reasons; and these patients generally do not refuse it for rational reasons alone. Finally, when involuntary treatment with anti-psychotic medication is administered it is efficacious clinically, restores trial-competency, and does not necessarily preclude favorable disposition of the pending criminal charges in non-death-penalty cases. The overall effects of involuntary medication at criminal trial have not been the subject of any direct empirical investigation that we are aware of, and it is precisely this area that raises

the greatest controversies and concerns. There is therefore a need for further research and, in its absence, we suggest that any pretrial defendant refusing medication should not be overridden without judicial review.

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