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The Disposition of Criminal Charges After Involuntary Medication to Restore Competency to Stand Trial

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ABSTRACT: The United States Supreme Court, in the recent case of *Riggins v. Nevada*, extended its examination of the issue of involuntary treatment with anti-psychotic medication to the mentally disabled facing criminal trial. Although this was an extreme case where the defendant faced a possible death sentence, the involuntary administration of anti-psychotic medication to restore 'competency to stand trial' always raises unique medical and moral questions. This highly controversial issue has received little empirical investigation.

We report here on the first study to follow-up on the disposition of the criminal charges of persons committed to a hospital for the restoration of 'competency to stand trial' who refused anti-psychotic medication and for whom involuntary treatment was sought. We have previously reported on the characteristics of these cases (N=68) and aspects of their outcome in the hospital. This cohort of patients represents virtually all indicted felony offenders in New York state who were incompetent to stand trial and for whom involuntary treatment with anti-psychotic medication was requested between 1986 and 1990. The present retrospective report focuses on the disposition of the criminal charges for such cases, in a state that does not have a death penalty.

Tentative inferences are considered based on the findings that persons who were involuntarily restored to 'competency to stand trial' had a variety of dispositions of their criminal charges, including plea negotiations that resulted in foreshortened incarceration and several cases of insanity acquittals. Suggestions for further and more conclusive studies are proposed.

KEYWORDS: psychiatry, competency, medication

The United States Supreme Court, in the recent case of *Riggins v. Nevada* [*1*], extended its examination of the issue of involuntary treatment with anti-psychotic medi-

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cation to the mentally disabled criminal defendant facing trial. The Court called attention to the paucity of empirical data on this important subject.

The issue of involuntarily administering anti-psychotic medication to restore a criminal defendant to competency raises unique medical and moral questions. The issue arises in the first place because of the requirement that criminal defendants be competent to stand trial. According to the Supreme Court's interpretation of the Constitution (see *2* and *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." Many criminal defendants are too psychiatrically impaired to meet this test (see for example, *4*), and are said to be incompetent to stand trial.

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 [*5*]. This restoration of trial-competency is commonly achieved through the administration of anti-psychotic medication.

There is much commentary in the legal literature (see for example, *6–18*), and many cases among lower courts (see for example, *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*]. There are even fewer empirical studies that focus specifically upon the *involuntary* administration of anti-psychotic medication to criminal defendants who have been adjudicated as incompetent to stand trial (see generally [*37–48*]).

We have reviewed the handful of empirical studies that have looked specifically at the involuntary medication of persons who have been adjudged incompetent to stand trial [*49*]. As we have noted, several of these studies are limited in the scope of their inquiry, the methodology they employ, or in their lack of outcome measures.

We have also reported on the initial stage of our research in this area [*50*]. That report appears to be the first to give research findings specifically for persons committed to a hospital for the restoration of competency to stand trial who refuse anti-psychotic medication and for whom judicial permission for involuntary treatment is requested. We studied all such cases in New York state, over a four and a half year period, involving criminal defendants who were under indictment for a felony. We found that involuntary treatment was generally effective both clinically and in restoring competency to stand trial.

The critical medical-legal question, however, is what becomes of these criminal defendants after they are involuntarily restored to trial-competency. Has the State imposed an unfair disadvantage upon these individuals by forcing them to proceed with their criminal case while experiencing the effects of the anti-psychotic medication? This position has been vociferously expressed by numerous legal commentators for decades, based on a wide variety of grounds (see for example, *6–18*). Some arguments are based on the efficacious effects of anti-psychotic medication. Perhaps, for example, forcibly medicating a defendant with anti-psychotic medication may make him appear too 'normal' to prevail with an insanity plea. Other arguments are based on the putative side effects of these medications. Perhaps, for example, the medication may adversely affect the defendant's motivation or cognitive capacity to defend himself.

Indeed, such concerns about potential adverse effects led Justice Kennedy, in *Riggins v. Nevada*, to indirectly suggest that a criminal defendant who refuses the anti-psychotic medication that could restore his trial-competency should have this refusal upheld. The State would then be faced with merely hospitalizing such an individual under civil law, assuming the individual meets commitment criteria, rather than proceeding with the criminal prosecution. Justice Kennedy cites limited empirical data in relation to this policy

position or its alternatives. Empirical data may be relevant to the public policy question of how to best handle the medication refusal of criminal defendants who are incompetent to stand trial. Special considerations do of course arise in cases, such as 'Riggins,' that involve the death penalty. However, neither such special cases, nor the more common cases that do not involve the death penalty, have received sufficient empirical study.

We report here on the first study that we know of to investigate the disposition of the criminal charges of criminal defendants who were restored to trial-competency through the involuntary administration of anti-psychotic medication. This study looked at defendants with a wide range of criminal charges, in a state that does not have a death penalty. We sought to determine what proportion of these cases ultimately end with convictions, acquittals or acquittals by reason of mental non-responsibility ('insanity')? Does the administration of involuntary anti-psychotic medication prevent acquittals or the successful use of the 'insanity defense,' as some have argued? To what extent does the disposition of criminal charges take the route of plea negotiations rather than actual criminal trials? If these incompetent to stand trial defendants were not involuntarily treated, as Justice Kennedy appears to propose for all such cases, would they be better off?

Methods

We limited our investigation to subjects who met several criteria. First, the individuals must have been adjudicated as 'incomptetent to stand trial' and committed to a hospital for the restoration of competency to stand trial. In New York, the statute mandates that misdemeanor offenders who are incompetent to stand trial must have their criminal charges dismissed and then be committed to a hospital. For this reason, a study in New York of the outcome of the criminal trial of formerly incompetent defendants must focus on felony offenders. 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 most 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, felony offenders who are not under indictment may be committed for only a brief period beyond which their charges must be dismissed.

The second criterion for inclusion in this study is refusal of anti-psychotic medication. We defined this narrowly to include only those persons whose refusal has led clinicians to seek judicial permission for involuntary treatment. As we have noted [*50*], this intentionally limits the study to cases of refusal that represent a small, but arguably most important, subset of all refusals. Thus, in this study 'refusal' is operationally defined as the filing, by the treating psychiatrist and clinical director, of an application to the court to treat the patient involuntarily. These applications are filed by clinicians in all state hospitals in New York, in accordance with the Office of Mental Health regulations which followed the 1986 *Rivers v. Katz* [*51*] decision.

The period under study begins with the inception of these regulations. We therefore aimed to include all indicted felony offenders who were incompetent to stand trial and for whom an application for involuntary treatment was filed between July, 1986 and December 31, 1990.

In this four and one half year study period, over 95% of all indicted felony offenders who were incompetent to stand trial in all of New York state were committed for the restoration of this competency to one of two maximum security facilities; Kirby or Mid-Hudson Forensic Psychiatric Center (based on personal communication, *52*). We therefore limited our inquiry to these two facilities.

As noted in our other report [*50*], there were 68 cases of application for involuntary treatment with anti-psychotic medication arising among 61 persons. All but one person were male. Approximately two-thirds (66%) of the subjects were single. The ethnicity

of the subjects was diverse; 31% were white, 54% were black and 13% were Hispanic. Approximately half (52%) were known to have graduated from high school. Approximately two-thirds (64%) of the subjects were known to have a previous psychiatric history and approximately 88% were known to have a prior criminal history. The applications to the court for involuntary treatment recorded a diagnosis of a psychotic disorder as defined in D.S.M.-III-R [*53*] for each subject, and few if any medical problems.

The design of this study includes a retrospective review of the hospital charts and the 'treatment over objection' application forms. In addition, follow-up data was obtained for all patients for a minimum of a year and a half after the date of the application for involuntary treatment and for most cases for several additional years.

This study reports information about the most serious of the criminal charges for which a given defendant is under indictment. Any additional charges which derived from the same criminal offense will be noted only were especially relevant. For purposes of this study, individuals were considered involuntarily medicated if they received medication after judicial permission for this was granted, and if they were not the subject of a subsequent new hearing that led to a denial of permission for involuntary treatment. (The one person in this latter category was considered not involuntarily medicated for purposes of investigating the disposition of his criminal charges.)

Provisions to ensure against breach of confidentiality were observed. Both the institutional review board and the state Office of Mental Health approved this study.

Results

Table 1 displays the primary criminal charge for which the defendants in this study were initially indicted. Over 80% of crimes were violent, but several, such as the sale of drugs, were not.

We have reported [*50*] that of the 68 cases of applications for involuntary treatment with anti-psychotic medication arising among the 61 involved defendants, there were 53 cases of applications that actually received a judicial hearing. In some judicial hearings the request for involuntary treatment was denied. Thus, these patients did not receive involuntary medication. For a variety of reasons, some patients did not actually receive involuntary medication even when judicial permission for involuntary medication had been granted. We now report on follow-up information on all 61 persons in the study, including the 43 persons who were involuntarily medicated and the 18 persons who in the end were not involuntarily medicated. (This latter number includes one person who

TABLE 1—*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 number	61

was involuntarily medicated but in a later episode of refusal permission for involuntary medication was not granted.)

In general, aggregate data will be provided for those persons involuntarily medicated. However, specific information will first be given for the 6 cases in which the request for involuntary treatment was judicially denied. In three of these cases, applications for involuntary medication were repeated at a subsequent date and judicial approval followed at that time. One of these defendants went to trial on charges of second degree Assault, was convicted of Assault with intent to cause physical injury and was sentenced to 1–3 years. One defendant reduced his charge through plea negotiation from second degree Robbery to Attempted Robbery and was sentenced to a period of 30 months to 5 years. The other defendant plea-bargained Criminal Sale of a Controlled Substance down to Criminal Possession of a Controlled Substance and was sentenced to 2 to 4 years.

In two of the six cases, the judicial ruling that the patient was competent to stand trial in the unmedicated state, and therefore involuntary medication was not permitted, was directly followed by a disposition of the criminal charge. In one of these cases, the defendant who was under indictment for Murder 2nd degree pled guilty to Manslaughter 1st degree (and was sentenced to 7–21 years). In the other case, the defendant under indictment for Grand Larceny 2nd degree, pled guilty to Grand Larceny 4th degree (and was given conditional discharge). In the final case of judicial denial of involuntary medication, the defendant pled guilty to the indictment charge of Attempted Robbery 3rd degree (and was sentenced to 2 to 4 years).

Aggregate Data

Table 2 shows the overall disposition of criminal charges for all 61 persons in the study. As noted, in nine cases the persons remained incompetent to stand trial at the end of the study period, there was one death, and one case in which the disposition remains undetermined. Thus, subtracting these cases, there were 50 cases in which the criminal charge was known to have received a true adjudication by the end of the study period.

Of these 50 cases, 42 (84%) resulted in a conviction on some charge. Since the majority of these cases involved the process of plea negotiation, the ultimate conviction was generally on a charge less severe than the indictment charge, as will be illustrated below. There were only seven cases that were known to proceed to actual criminal trial, of which six resulted in a conviction (one resulted in an insanity acquittal, see below). Only two of these trials were known to involve a jury. In two of the six trials that

TABLE 2—*Overall disposition of criminal charges* (n = *61*).

Outcome		Total
Conviction:		42
plea	36	
jury trial	2	
non-jury trial	3	
jury?	1	
Insanity acquittal		6
Jackson proceedings		2
(Sub-total)		(50)
Still I.S.T.		9
Death		1
Undetermined		1
Total		61

resulted in a conviction, the defendant pled not guilty, and in the other four cases it is not known if the defendant pled not guilty or insanity.

Of the 50 adjudicated cases, there were 6 (12%) that resulted in insanity acquittals. These acquittals were by plea negotiation in 5 cases. In one case the acquittal was a verdict at criminal trial. It is not known if this case involved a jury. There were 2 (4% of the 50) cases that resulted in Jackson proceedings. As the Supreme Court stated in *Jackson versus Indiana* [5], when a defendant cannot be restored to competency to stand trial further hospital commitment must be through the more liberal mechanism of civil law rather than criminal law. Criminal charges may be dropped after the Jackson proceeding is instituted, as appears to have been the case with the two individuals in this study, one who had been under indictment for Attempted Murder, and the other for Assault, second degree.

Table 3 shows the outcome of the criminal charges for all persons in the study, separating them into two groups depending on whether they in fact received involuntary medication. Of the 61 patients, 43 were medicated involuntarily. In the other cases the applications were withdrawn, judicially denied, or in two cases the patient did not receive involuntary medication for another reason, and in one case a subsequent hearing resulted in no involuntary medication.

The sub-group who did not receive involuntary medication may be different from the group that did receive involuntary medication in ways that could impact on the outcome of the disposition of criminal charges. For this reason, the former group does not constitute a true control group for purposes of statistical comparison. The size of the groups are in any event too small for conclusive comparisons. Nonetheless, some informal comparisons may be made between these two sub-groups of this single cohort.

As can be seen from the table, among the involuntarily medicated group there was one case of death and seven persons who remained incompetent to stand trial at the end of the study period. Excluding these cases, there were 35 persons who were involuntarily medicated who had a known disposition of their criminal charges. The outcome of criminal charges is also shown for the analogous 15 persons who were *not* involuntarily medicated.

Of the 35 persons involuntarily restored who were either convicted, acquitted or 'Jacksoned,' 28 (80%) were convicted after they had their competency to stand trial restored (and the majority were then sentenced to state prison). In 24 of these 35 cases, conviction came about through plea negotiation. Thus, for more than two-thirds (68.6%) of all involuntarily medicated defendants who received final disposition on their case, plea

TABLE 3—*Outcome of the criminal charges (n = 61 persons).*

	Number of persons		
Outcome	involuntarily medicated	not	Total
Conviction	28	14	42
plea	(24)	(12)	(36)
jury trial	(1)	(1)	(2)
non-jury trial	(3)	(0)	(3)
jury?	(0)	(1)	(1)
Insanity acquittal	5	1	6
Jackson proceeding	2	0	2
Sub-total	(35)	(15)	(50)
Still in hospital as incompetent to stand trial	7	2	9
Death	1	0	1
Undetermined	0	1	1
Total	43	18	61

bargaining was used in which the charge is generally lowered to a less serious offense in exchange for a guilty plea.

Of the 15 persons who did not receive involuntary medication (not counting those still incompetent to stand trial, and the one case that is undetermined), 14 (93%) were later convicted. These numbers seem comparable to the group that was medicated involuntarily.

Five (14.3%) of the 35 involuntarily restored patients, who had their charges adjudicated, were acquitted by reason of mental non-responsibility, in one case through trial. Although the two sub-groups are not controlled for potentially important differences, we may note in passing that the overall frequency of insanity acquittals among the persons who did not receive involuntary medication was lower.

In two of 35 (5.7%) persons involuntarily restored, who had their charges adjudicated, the criminal charges appear to have been dismissed following a 'Jackson' proceeding, as mentioned earlier. There were no Jackson proceedings among the sub-group of patients who did not receive involuntary medication. As long as involuntary medication remained an option, it seems that defendants were not viewed as permanently incompetent.

Table 3 also reveals a total of seven involuntarily medicated patients who were in the hospital as incompetent to stand trial at the end of this study period. This group includes five re-admissions. These patients generally needed re-admission because of clinical decompensation that developed after the patients were returned to the local jails, where in New York, medication is not administered on an involuntary basis.

Table 4 shows what the initial charges were for each category of final disposition. For example, the group that ultimately received convictions included defendants who had a wide variety of original indictment charges. As noted earlier, persons in this group typically had their criminal charges reduced through the plea bargaining process. As the table shows, the cases of insanity acquittal were typically, but not exclusively among those charged with very serious crimes. The Jackson proceedings seemed to occur among those charged with offenses of intermediate severity.

We may infer from the table that many defendants with the relatively less serious

TABLE 4—*Initial charge of persons ultimately adjudicated (n = 50).*

		Number of Persons:		
Disposition	Initial charge	Invol. medicated	not	Total
Conviction				
	Murder	3	2	5
	Attempted murder	3	2	5
	Assault	8	3	11
	Robbery (or att.)	3	3	6
	Burglary	4	3	7
	Grand larceny	0	1	1
	Arson (or att.)	3	0	3
	Sexual abuse	1	0	1
	CSCS	1	0	1
	CPW	1	0	1
	Reckless end.	1	0	1
Insanity acquittal:				
	Murder	4	0	4
	Kidnapping	1	0	1
	Burglary	0	1	1
'Jacksoned':				
	Attempted murder	1	0	1
	Assault	1	0	1
Total		35	15	50

felony charges had dispositions of these charges that led to relatively early release from incarceration whether they were involuntarily medicated or not. This inference is based on the high proportion of plea bargaining, several cases of which resulted in markedly reduced sentences.

This can be illustrated by examining the disposition of the eleven persons initially indicted for Assault, which were either in the 1st or 2nd degree. Excluding the one case leading to a Jackson proceeding, there were 8 defendants who were involuntarity medicated and three that were not. Of the eight defendants involuntarily medicated, one was convicted at trial and 7 negotiated a plea. The sentencing patterns for these cases of defendants who were incarcerated pending the involuntary restoration of their trial-competency, are illustrative of the potentially favorable outcome of the adjudication of serious criminal charges especially through plea-bargaining to less severe offenses. The defendant convicted at trial was sentenced to 1–3 years in prison. However, because of the prolonged period of confinement prior to trial, including 15 months in the hospital as an incompetent defendant, he was in fact released on parole 2 weeks after his criminal trial.

The sentences for the seven defendants who negotiated a plea included two defendants who pled down to Attempted Assault and were sentenced merely to probation. These two defendants spent either 1 or 2 years in the pre-trial phase, either in the hospital or jail, while they were being held on the more serious charge of Assault for which they were originally indicted. One defendant spent 7 years confined in the pre-trial phase, pled guilty to Attempted Assault, was sentenced to 1 year and was released on parole within 8 months. Of the other defendants who entered guilty pleas to what were generally reduced charges, one person was confined nearly three years in the pre-trial phase and was released on parole 2 weeks after being sentenced to 1–3 years. Three other defendants, each of whom had spent over a year confined in the pre-trial phase, accepted guilty pleas to lower offenses, were sentenced to $1^1/_2$–3 years (one was released on parole 4 months later). Finally, one defendant who was confined for 1 year pre-trial, took a plea, was sentenced to 2–4 years and was paroled 21 months later. (More than half of these defendants were admitted to an in-patient psychiatric facility for treatment during the period of their subsequent prison sentence.)

In addition to the two defendants charged with Assault, there were other defendants who after being involuntarily medicated and restored to competency gained immediate release. This was the case for some defendants whose initial indictment was on charges of Arson, Attempted Arson, or Burglary.

Murder

Table 5 shows findings specific to those defendants who were under indictment for Murder. The ultimate outcome of involuntary restoration of trial-competency with medication for cases having among the most serious charges of the cohort can be seen.

TABLE 5—*Disposition for murder indictments (n = 14).*

	Number of persons		
Outcome	Invol. medicated	Not	Total
Still I.S.T.	4	1	5
'Jacksoned'	0	0	0
Insanity Acquittal	4	0	4
Convictions:			
plea	2	2	4
jury trial	0	0	0
non-jury trial	1	0	1
Total	11	3	14

There were 14 cases of known disposition in which Murder was the initial charge. In 11 of these 14 cases involuntary medication was administered, in three cases it was not. As Table 5 shows, more than half of those charged with Murder who were involuntarily medicated and who have had a final disposition of their charges, were acquitted by reason of insanity. Two others pled guilty to the lesser charge of Manslaughter, and one was convicted of Murder after a non-jury trial. There were no cases involving jury trials from this group charged with Murder. We may note in passing, that the defendants who were indicted for Murder and who were spared involuntary medication and went on with their criminal case, were not spared convictions. In the two such cases adjudicated, they too pled guilty to Manslaughter.

Attempted Murder

There were fewer cases in this cohort that involved indictment for Attempted Murder (n=8). This group may deserve particular mention because at least with respect to the intent of the offense it is as serious as Murder and often differs only with the strength or type of weapon used. As Table 6 shows, of the involuntarily medicated defendants indicted for Attempted Murder, one died, one received a Jackson proceeding, one was still incompetent at the end of the study period, one entered a plea of guilty to Assault (and received a 2–6 year sentence), and two were convicted of Attempted Murder at trial. It should be noted that these criminal trials, one of which did not involve a jury, took place well over a year after the discharge from the hospitalization in which involuntary medication was administered. There were two defendants indicted for Attempted Murder who were not involuntarily medicated, both of whom entered plea negotiation.

Previous Convictions

Of the 28 defendants in this study who ultimately received a conviction after being involuntarily medicated, 13 were known to have had previous felony convictions, 10 had previous misdemeanor convictions and 5 were not known to have had previous convictions (though they may have had previous arrests).

Time to Plea Adjudication

Once restored to trial-competency, patients were discharged from the hospital and returned to jail to await their case. Often there was considerable delay before the adjudication took place. Of the involuntarily medicated defendants who pled guilty for whom this information is known (n = 20), only 2 had their case adjudicated within 1 month of discharge, for 10 it took up to 3 months, and for 8 defendants additional delays ensued.

TABLE 6—*Disposition for attempted murder indictments (n = 8).*

Outcome	Number of persons		
	Invol. medicated	Not	Total
Still I.S.T.	1	0	1
Jacksoned	1	0	1
Death	1	0	1
Insanity acquittal	0	0	0
Convictions:			
plea	1	2	3
jury trial	1	0	1
non-jury trial	1	0	1
Total	6	2	8

Subsequent Hospitalizations

Approximately two-thirds of the defendants who were involuntarily medicated and convicted were later admitted to the in-patient psychiatric facility for sentenced prisoners.

Discussion

This is the first study that we are aware of that examines the outcome of criminal charges specifically among criminal defendants whose competency to stand trial was restored through the involuntary administration of anti-psychotic medication. We have determined how the criminal charges were ultimately disposed of for the criminal defendants in this study. Some defendants were ultimately convicted, some were acquitted by reason of insanity, and several had their charges dismissed after a Jackson proceeding.

Although the defendants in this study were committed to a hospital because they were incompetent to stand *trial*, few of them would ever actually proceed to a criminal trial. There were only seven cases that involved an actual criminal trial of the 50 cases that received final adjudication of the criminal charges, or 14% of all cases.

In approximately two-thirds of all involuntarily medicated defendants who received final disposition of their case, the process of plea bargaining was used in which the criminal charge is lowered to a less serious offense in exchange for a guilty plea. This high proportion of plea negotiations suggests that a discussion of the involuntary administration of anti-psychotic medication to restore 'competency to stand trial' should consider as well the issue of 'competency to plead.' The issue of plea negotiations is also relevant to several of the issues mentioned below.

In discussing the results of this study some general comparisons will be made between the experience of those who were involuntarily restored to trial-competency and those for whom such treatment was sought but not actually administered. This latter group is relevant since it represents persons who have been selected in identical ways to the group of persons who were involuntarily medicated. In other words, the sub-group of persons reported on here who did not receive involuntary medication were also indicted felony offenders who were incompetent to stand trial, were committed to the same facilities during the same period of time, and were the subjects of identical applications for involuntary medication submitted by the same group of clinicians. They differ in that for a variety of reasons they did not receive involuntary medication.

The limitations inherent in comparing these two groups is the problem of potential 'selection bias.' To some extent, not receiving involuntary medication might reflect certain factors which may also have an impact on the outcome measured, namely, the disposition of criminal charges. For example, of the 18 patients in this study who did not receive medication involuntarily there were three cases in which the patients' refusal was judicially upheld and then directly followed by the disposition of the criminal charges. Perhaps, these individual had their refusal upheld because they were indeed less psychiatrically impaired even without medication than were some of the other patients in this study. To the extent that this was so, then for this same reason their higher level of mental functioning may have been helpful in defending themselves and in negotiating their plea arrangements.

Thus, the two groups are not truly 'matched' to differ only with respect to the intervention under study, which is involuntary medication. Nonetheless, on the assumption that the group that did not receive involuntary medication was generally less psychiatrically impaired and better able to defend themselves than the group that did require and receive such treatment, we would expect the former group to at least do no worse on average than the latter group. This is especially true if involuntary medication per se further impairs a defendant, as some authors have speculated. For this reason, some examination of both groups seems potentially of value in the discussion that follows.

The findings of the present study are of some relevance to several conceptual issues, which will be discussed separately. It should be noted that although the *Riggins* death penalty case is used in this discussion, our study sample spanned the gamut of felony criminal charges in a state with no death penalty. We do not intend to extrapolate from cases that do not involve the death penalty to cases that do.

1. Does involuntary medication 'impair' the defendant's ultimate disposition?

The primary question, for which the Supreme Court granted certiorari in *Riggins v. Nevada*, is whether forced administration of anti-psychotic medication during a criminal trial to *maintain* competency to stand trial interferes with the defendant's rights to a fair trial. The Court also discussed in its opinion the related issue of whether such medication can be administered to *restore* trial-competency in the first place. These questions in turn contain two major components. One concern is that the defendant will be impaired, the other concern is that he will not be impaired enough. This latter concern arises most clearly when a defendant pleading 'insanity' appears too 'normal' for the trier of fact, usually a jury, to be likely to accept his defense. These concerns may be uniquely present in death penalty cases, but pertain as well to all cases.

The *Riggins* majority decision did not fully address these critical issues. It seemed to imply, however, that given certain procedural safeguards it can be Constitutionally permissible to forcibly restore a defendant to trial-competency and that it is possible to ensure that he receives a fair trial. As we noted in the introduction, Justice Kennedy, in a concurring opinion, was much more skeptical that present medical knowledge could ever justifiably allow the involuntary administration of medication for the purpose of restoring trial-competency. He instead appeared to favor civil commitment, rather than criminal proceedings, as the means to process these mentally disabled criminal defendants. It remains to be seen how the lower courts will interpret the *Riggins* case, and whether Justice Kennedy's alternative public policy suggestion will be adopted. Some of the data from studies such as the present one, may be relevant to the lower courts in their consideration of these issues in non-death penalty cases.

Since plea bargaining rather than an actual trial served as the final mechanism of adjudication for most of the defendants in this study, the information on the effects of involuntary restoration on the defendant during an actual trial is limited. This is further limited by uncertainty about whether a defendant was actually medicated at the time of trial, as we note below. However, it is noteworthy that of the six cases that resulted in convictions at an actual trial, four cases involved involuntarily medicated defendants during a pre-trial hospitalization and two involved defendants who had *not* received involuntary medication. As Table 3 indicates, this represents about equal proportions of those defendants who were and of those who were not forcibly medicated (since a larger number of the defendants in this study were involuntarily medicated). These numbers of subjects are very small and no information is available concerning medication at the time of actual trial. The data presented here concerning actual trials therefore merely serve to call for further study.

More generally, the issue of whether involuntary medication 'impairs' the otherwise incompetent defendant may be addressed on several levels. To be sure, the *Riggins* case focuses on potential impairment at a criminal trial. However, the more common means in everyday life to dispose of criminal charges is through plea-bargaining. This is at least the case where the death penalty is not at issue. As this study shows, the use of plea-bargaining predominates as well among criminal defendants who have been involuntarily restored to trial-competency. Does involuntary medication 'impair' this process?

The present findings appear to suggest that in general, involuntary medication does not impair this overall process of the disposition of criminal charges. First and foremost, the data reveal that through the plea negotiation process some relatively favorable dis-

positions were brought about. Many of the individuals had their charges markedly reduced. Several individuals gained freedom from confinement immediately through these favorable dispositions. All of these individuals may very well not have gained this freedom for much longer periods of time had Justice Kennedy's alternative disposition of civil commitment been followed. Indeed, patients in this study who were not restored to competency to stand trial remained in the hospital for prolonged periods, as did several individuals who were civilly committed through the 'Jackson' route. From the point of view of civil liberties, therefore, forced restoration with medication may be intrusive in the short-term, but may sometimes be liberating in the long-term. While criminal convictions entail considerable stigma, it is relevant to note that nearly all of the defendants who agreed to a guilty plea already had previous convictions.

An indirect measure of the effects of involuntary medication on the overall process may also be gained from a comparison between those persons medicated involuntarily and those who were not so treated. In addition, an examination of the most serious cases, the 14 cases of indictment for murder seven of whom were medicated involuntarily and received a final adjudication of their charge (see Table 5), suggest that overall the effects of involuntary medication did not preclude relatively favorable outcomes for the subjects in this study with the most serious charges. It did not preclude insanity acquittals, and it did indeed allow potentially favorable plea negotiations.

In addition, at least with respect to the plea negotiation process, and on the presumption that the defendants were indeed on medication involuntarily at the time of such proceedings, then the data presented here 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 such individuals. Justice Kennedy expressed concerns about potentially deleterious effects on the defendant at criminal trial. His public policy recommendation, however, might adversely impact upon some individuals who, like some of those in this study, could receive relatively favorable outcomes once restored to trial-competency. This potential benefit might of course be easily offset in states that, unlike New York, lack rigorous legal advocates for the mentally disabled (both while in the hospital and at trial) or that have a death penalty. In death penalty cases the stakes are uniquely high and plea bargaining is often not available as an option.

Since this study involves a small number of cases, includes assumptions that are central to the issue under discussion (for example, whether medication was in fact administered at the time of the adjudication of the charge), and has the other limitations mentioned below, the inferences mentioned remain areas of uncertainty and best serve to guide further study.

We may note in passing, that the data in this study do not shed direct light on possible effects of the involuntary administration of anti-psychotic medications on, to quote again from Justice Kennedy, the defendants' "*willingness* to react . . . at trial. . ." It is not clear, however, why, this concern about such effects of the medication arises only when the medication is administered involuntarily. The great majority of trial-incompetent defendants are restored to trial-competency through the voluntary use of these same medications. Why does Justice Kennedy not express concern about the possible effects on the "willingness" of all such individuals. This is one of what might be called the "Riddles in 'Riggins.' "

2. Is involuntary treatment *too* effective?

Does restoring trial-competency diminish the likelihood of prevailing with a mental state defense? The data from this study on this question certainly reveal a high proportion of convictions for a population with very severe mental illness. Indeed, these patients were mentally disabled to such a degree that approximately two-thirds of the involun-

tarily medicated subjects from this study who were sentenced to prison later required transfer to an acute in-patient psychiatric ward designed for sentenced prisoners. One might therefore have predicted in general a higher proportion of mental-state related mitigating or exculpating defenses.

The present findings, however, do suggest that the administration of involuntary medication to restore competency to stand trial does not always preclude the successful assertion of an insanity plea, as noted above. Although the small numbers in this sample limits generalizability, it is interesting to note that the proportion of insanity acquittals was greater among those persons who were involuntarily medicated than among those who did not receive such treatment (see Table 3). We may speculate that this reflects the greater psychopathology among a sub-group of patients. Perhaps, these more disturbed patients are selectively more likely to receive involuntary treatment since their psychiatric symptomatology is obvious both to clinicians and judges, and for the same reason their defense of insanity may seem more credible. However, the number of subjects in the two sub-groups with identical charges severe enough to make an insanity plea a likely legal strategy, is too small to allow any definite conclusions to be drawn. It should also be mentioned, that the visible presence of psychosis in a defendant may be of special significance where a jury is considering a death sentence. This study does not address this question.

3. What is the 'best interests' of the individual?

One additional quandary that arises uniquely with the medication refusal of criminal defendants who are incompetent to stand trial, is the issue of the mentally disabled offenders' "best interests." In New York, the second prong of the *Rivers* review process regarding clinicians' request for involuntary medication requires judges to make a finding about the "best interests" of any patient who refuses medication for whom an override is requested. A determination that the patient lacks decision-making capacity is not enough for involuntary treatment to be authorized. Treatment must also be in a patients' "best interests." In applying the *Rivers* decision to persons who are incompetent to stand trial, a unique complication arises.

For all other categories of medication-refusing patients, the "best interests" of the *patient* centers largely on the patient's clinical welfare. In contrast, determining the criminal *defendants*' "best interests" may be an altogether different matter. It may, for example, be in the "best interests" of a defendant facing several separate counts of murder (of which there was one case in this study) to remain incompetent to stand trial rather than risk losing a criminal trial and spending a lifetime in the less protective environment of a state prison. What is in this patient's "best interests"? Who should decide, and how?

Perhaps, nowhere is this question as pressing as in the states outside of New York, the majority of which have a death penalty. With life and death at stake it could be argued in many instances that the patient's "best interests" would be to remain incompetent to stand trial. Although in theory one might attempt to justify involuntary treatment even if it came at the expense of a defendant's overall welfare, as long it promoted *justice*, this idea is problematic and runs contrary to commonly accepted notions concerning ethical principles of treatment. Treatment, even when it is involuntary, is generally thought to be for the patient's "best interests."

On the basis of the current study, it would seem that in New York an analysis of the "best interests" of the patient-defendant should include the anti-psychotic medication's beneficial potential to allow the defendant to regain 'competency to stand trial' and then enter plea negotiation. This issue is of especial importance because New York statute authorizes the continued involuntary hospitalization of an indicted felony offender who is incompetent to stand trial for periods of time that are in proportion to the most lengthy

sentence the individual could receive if found guilty. Thus, an individual may be hospitalized for prolonged periods based on the indictment charge even though there is a great likelihood that a plea to a much lesser charge would be accepted, and that such a reduced charge would not warrant prolonged incarceration or continued involuntary hospitalization. The findings from this study provide many cases that illustrate this point. One defendant was in and out of the hospital and jails for *seven* years, and after being restored to trial-competence entered a guilty plea to less severe charges and was then paroled 8 months later.

With regard to the process of judicial review in New York, we may also ask in passing whether, after the *Riggins* decision, the *Rivers* analysis provides a sufficient framework for the adjudication of medication refusal by hospitalized trial-incompetent defendants. Though *Rivers* requires an inquiry into the "best interests" of the patient, it divorces this clinical inquiry of hospital treatment from an inquiry into the potential effects of the medication upon the defendant at his future criminal trial or plea-bargaining process.

Indeed, the overall process for handling incompetent defendants in New York similarly divorces the pre-trial defendants' treatment in the hospital from the treatment of these defendants in the local jails as they await their criminal trial. The present study found that involuntary medication in the hospital was frequently followed by sufficient improvement to allow discharge to jail where the defendant would then clinically deteriorate when off medication. This resulted from the policy in New York of not continuing involuntary medication in the jail setting. As Table 3 reveals, there were seven persons involuntarily medicated who were in the hospital as incompetent to stand trial at the end of the study period. This group includes five re-admissions that were brought about because of the correctional system's practice of discontinuing the forced medication that was judicially ordered while the patient was in the hospital. This area calls for further inquiry.

4. Should 'Competency to Stand *Trial*' be the standard?

This study indicates that, at least for indicted felony offenders in New York state who have been forcibly medicated and restored to competency, plea negotiation is the most common mechanism for the adjudication of the pending criminal charges. Actual criminal trials are relatively uncommon. Despite this empirical reality, defendants are routinely evaluated for competency to stand *trial*, rather than competency to *plead*. Although the U.S. Supreme Court has recently found [54] that the same standard of mental functioning may apply in either case, the availability of a plea offer should not be ignored.

It would seem that an argument could be made that when a criminal offender is committed to a hospital to regain competency to stand trial and refuses medication, an inquiry should be made about whether indeed a plea bargain has been offered to the defendant. This type of inquiry is not routinely done at the hearing pertaining to involuntary medication of these patients. Since these hearings attempt to determine the "best interest" of the patient-defendant, as noted above, the question of a plea bargain offer that could shorten incarceration seems germane.

This illustrates a potentially problematic aspect of the way in which incompetent defendants are managed in New York state. These individuals are transferred between two separate systems, the mental health system and the criminal justice system. Two apparent problems with this bifurcated system were mentioned above; judicial orders for involuntary medication are not continued upon transfer to the correctional system, and hearings pertaining to involuntary medication address the "best interests" of the defendant without necessarily addressing the pending criminal case at all.

It may now be further added that in New York the legal representation of an indigent person while in one system is separate from that which is provided when the same person is transferred to the other system. The goals and priorities of the legal advocates from

these two systems may differ. The patient's lawyer in the hospital advocating to uphold the patient's refusal of medication is not necessarily in communication with, or in agreement with the strategy of, the patients' defense attorney on the pending criminal charges.

Although in practice, the hospital lawyers do in fact often communicate with the criminal defense attorneys, in some cases it is possible that they may not know of, or be directly concerned with, the availability of a plea offer to the patient-defendant. For the hospital lawyer, advocating the patient's 'right to refuse' may seem to be the pressing priority. In contrast, for the criminal defense attorney disposing of a criminal charge and attaining the most rapid release from confinement may seem to be the most pressing priorities. There is no formal mechanism in place for resolving the dilemmas which these different priorities may sometimes produce. Although New York state provides vigorous legal advocacy for all hospitalized patients, and many other states do not, the current system in New York may still benefit from further consideration of some of the issues mentioned here.

5. Comparisons to other studies

While some studies [*55–58*] look at aspects of the outcome of criminal defendants referred for *evaluation* of 'competency to stand trial,' few studies have looked specifically at individuals who have been *restored* to 'competency to stand trial.' One study [*57*] found no difference in sentencing patterns among such defendants and the general criminal defendant population. Another study [*58*] reported on a group of subjects that included misdemeanor offenders and felony offenders who were not necessarily under indictment. It reported that about a third of all the defendants in the study whose trial-competency was restored were sent to state prison, and apparently an additional unclear number of defendants were convicted but not sentenced to state prison and about 8% were acquitted by reason of 'insanity.' Additional information such as the proportions of the convictions that were actual trials or plea bargaining were also not reported.

We are not aware of any study that examined the outcome of criminal charges specifically among defendants whose 'competency to stand trial' was restored through the *involuntary* administration of medication. Our findings with involuntarily medicated indicted felony offenders are difficult to compare to the few other studies in this area that do not limit their inquiry to a population that has psychiatric impairment and faces criminal charges of such a severe dimension.

Some of the findings in our study when compared to the above noted report [*58*] may suggest that involuntary treatment per se may not necessarily create obvious disadvantage to the criminal defendant. To take one example, we have noted that approximately 14% of the involuntarily medicated defendants in our study who received a final disposition received insanity acquittals. This proportion is higher than the number provided in that previous report regarding a mixed group of defendants who were not involuntarily medicated.

Conclusions

The experience in New York with criminal defendants involuntarily restored to competency to stand trial seems important for several reasons. First, based on recent data [*59*] we may extrapolate that New York state has, at a given point in time, approximately 10% of the entire nation's state hospital population of patients committed as 'incompetent to stand trial.' Thus, New York handles a large proportion of these cases. In addition, we are not aware of any similar studies conducted elsewhere.

Since this study involves a small number of subjects, and has a number of other very important limitations as mentioned below, it does not lend itself to definite conclusions. Nonetheless, several tentative inferences may be considered on the basis of the findings reported here for defendants in New York state, including the following:

1. Judicial denial of involuntary treatment with anti-psychotic medication is sometimes followed by subsequent convictions, rather than acquittals on the pending criminal charges.
2. Forced medication for restoration to 'competency to stand trial' does not preclude the subsequent successful use of an 'insanity defense.'
3. Indicted felony offenders in New York who have been involuntarily medicated and restored to trial-competency most commonly face the plea negotiation process rather than actual criminal trial.
4. Forced medication to restore 'competency to stand trial' does not preclude the subsequent use of the plea negotiation process in ways that sometimes favorably limit the period of confinement, and at times eventuate in immediate release.
5. There is no evidence from this study that forced medication per se during a pre-trial hospitalization worsens the outcome of pending criminal charges.

Limitations and Future Research

This study has the same limitations that inhere to any retrospective descriptive study. In addition, the outcome of this sample of patients are not formally compared with statistics to the outcome of a true control group. An appropriate control group would match on diagnosis, severity of psychiatric symptoms, and on the number and severity of criminal charges.

The current data are also not yet fully informative on many of the related issues that forced medication to restore trial-competency raises. For example, of the seven defendants that had an actual criminal trial it is not yet known for four what pleas were entered at trial. They may or may not have entered insanity pleas. In addition, and importantly, it is not yet known whether these defendants, or the other defendants in this study, were actually on medication at all at the time of the trial or on the day of plea adjudication.

Conclusive statements about the effects of involuntary medication on 'incompetent to stand trial' defendants thus requires further research to determine whether the defendants received medication at trial or at the time of plea adjudication, and to compare the outcome in these cases to defendants who are similar in all respects except for not receiving involuntary medication.

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, and given the lack of a previous study similar to the present one, the descriptive information that we present here may be useful. We hope that it helps delineate some of the boundaries, and adds some empirical data, to some of the complex issues involved in the involuntary treatment of people who are 'incompetent to stand trial.'

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