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Involuntary Electro-Convulsive Therapy to Restore Competency to Stand Trial: A Five Year Study in New York State

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ABSTRACT: As a result of the recent United States Supreme Court case of *Riggins v. Nevada,* lower courts are likely to review if, and under what conditions, pretrial criminal defendants may be treated involuntarily with antipsychotic medication. It may also be time to re-consider the similar use of electro-convulsive therapy (ECT), if indeed it is still being used in this context. This is the first known recent study to determine the frequency of ECT among incompetent defendants. Records from the two forensic psychiatric facilities in New York State that receive over 95% of all indicted felony offenders who are incompetent to stand trial were retrospectively reviewed for a five year study period. All requests to the court for authorization for involuntary treatment with ECT were sought. In the study period, out of approximately 1365 total persons committed, there was one case of a request to the court to administer involuntary ECT to an incompetent defendant. This request was granted after a *Rivers* hearing. This single case, in which involuntary ECT was not effective, is described. This study serves to demonstrate that involuntary ECT is still requested and administered in New York State to incompetent defendants. In light of the concerns raised in *Riggins* about involuntary medication, it seems reasonable and necessary to re-consider whether and under what conditions ECT should be involuntarily administered to a pre-trial defendant. Several recommendations are suggested.

KEYWORDS: psychiatry, electro-convulsive therapy, involuntary, incompetent, criminal defendant, *Riggins v. Nevada,* treatment, jurisprudence, legal rights

Criminal defendants who suffer from severe mental disorders cannot be subjected to a criminal trial if they cannot understand the legal proceedings or cannot rationally consult an attorney in their own defense [*1*]. Criminal defendants whose current mental disorders interfere with these capacities are said to be 'incompetent to stand trial.' These defendants may be committed to a hospital for psychiatric treatment and once they are restored to competency they may then be returned to court to face their pending criminal charges.

Important questions arise when criminal defendants who are incompetent to stand trial refuse the psychiatric treatment that could restore them to the required condition of competency to stand trial. Almost all of the recent intense debates regarding the involuntary administration of treatment to such defendants has focused on the use of anti-psychotic medication [*2–11*]. There is an extensive literature on this issue, including several related empirical studies [*12,13*], and the United States Supreme Court has recently indirectly commented on aspects of this issue [*14*].

In the 1992 case of *Riggins versus Nevada* [*14*], the Supreme Court held that a State cannot force a criminal defendant to take antipsychotic medication at criminal trial without at least demonstrating the need for such treatment at a judicial hearing. The Court discussed at length, in its dicta, ways in which the side effects of such medication could have an adverse impact on a criminal defendant at trial, including by causing adverse effects on cognition. The Court held that to force medication upon a defendant, without at least adequately considering these adverse effects and any overriding justification for such treatment, violates the defendant's rights to a fair trial.

It remains to be seen how the lower courts will resolve the numerous questions that were raised and then left unanswered in the *Riggins* decision. Over the next several years the lower courts and state legislatures are likely to re-examine the various laws and practices concerning criminal defendants who refuse antipsychotic medication. While this process takes place it may also be a useful time to reconsider the analogous issues that obtain with forcing criminal defendants to receive other forms of psychiatric treatments, including electro-convulsive therapy (ECT).

Should forced ECT be administered to a criminal defendant who is incompetent to stand trial and who is thought to need this treatment to be restored to competency? Or should criminal defendants have a special right to refuse such treatment? This situation raises several ethical and legal questions that are unique to ECT and do not pertain to treatment with antipsychotic medication. Given the high stakes of a criminal trial, particularly in the majority of states that have the death penalty, it is somewhat surprising how little attention this issue has received in the forensic psychiatric literature, even if in practice this issue arises infrequently. A literature search failed to uncover any empirical research studies in this area. Many articles on the treatment of incompetent defendants make no mention of ECT at all [*15–22*].

Numerous criminal cases involving defendants who received ECT were heard in the 1970s in both state and federal courts (see for example, [*23–34*]) but far fewer, if any, recent courts have dealt with this issue, and none are yet known to have been reported

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since the *Riggins* decision. The court decisions of previous decades may not be fully applicable today in light of the important advances in the technology and in the methods of administration of ECT that have markedly enhanced its safety. These changes might now more readily provide the basis to justify forced ECT in some contexts than was possible in the past. On the other hand, the increased attention and concern shown by the Supreme Court regarding the potentially adverse effects of psychiatric treatments upon a criminal defendant might very well militate even more strongly now against such treatments in this context.

The central concern that could arise with forcing a criminal defendant to receive ECT is its potential adverse effects on an individual's memory capabilities. The American Bar Association Criminal Justice Mental Health Standards [*35*] takes the position that, "Defendants and their counsel have a constitutionally protected interest in preserving defendant mental processes requisite to an adequate factual or legal defense. There is some claim, for example, that the administration of electroconvulsive therapy impairs short-term memory. If this were so, that form of treatment could affect adversely a defendant's ability to present a defense and should not be permitted if the defense objects."

Whether or not ECT adversely affects memory, and if so to what degree, are questions that have not been completely resolved in the psychiatric literature. There is certainly substantial data to suggest that ECT poses a risk for a subset of patients to develop some adverse impact on aspects of memory for at least a limited period of time. There are in addition reports of some individuals experiencing severe memory problems that seem to persist. Taken as a whole, the empirical literature on psychiatric treatments appears to lend greater cause for concern about treatment-induced adverse effects on cognition, and especially about potentially permanent effects, when ECT is administered compared to the likelihood of such effects when antipsychotic medication is administered.

These adverse effects may also be of greater relevance in the legal arena than they are in the general clinical context. For example, if ECT causes retrograde amnesia for events that occurred in the period just prior to the treatments, this might pose little problem for most civil patients who may have no particular need to recall the events leading up to the period of treatment. However, the same type of memory problems may pose immeasurable problems for a defendant trying to recall the events of a crime that is alleged to have occurred in the period prior to the ECT treatments. This type of consideration could be advanced to lend special support to a criminal defendant's right to refuse ECT. Opposite considerations may also be advanced. For example, in contrast to the situation involving antipsychotic medication in which typically the defendant is subjected to adjudication while experiencing the effects of such medication, successful ECT could theoretically result in marked improvement, resulting in there being no need for the defendant to go to trial under the effects of any active external agents.

While appellate decisions in the past have reviewed isolated cases of criminal defendants subjected to ECT, renewed attention to this area seems fitting in the wake of *Riggins*. Toward this end, updated data about the state of current practice could be useful. The first question that needs to be addressed is: how frequently, if at all, do such cases currently arise? One of the aims of the present study is to determine this matter in New York State.

The second issue to investigate relates to the outcome of the process in use to review a defendant's refusal of ECT treatment. The 1986 *Rivers v. Katz* [*36*] decision established new law in New York State regarding involuntary treatment. For such treatment to be permitted, the new law required a judicial hearing to review a patient's objections and a judicial determination that the patient lacked the capacity to make treatment decisions and also that such treatment was in the patient's best interests. While in one psychiatric research report [*37*] it was written that this law does not apply to ECT, the practice in State-operated facilities is indeed to request a court hearing before involuntarily administering ECT (The necessity for this practice also seems supported by *Salisbury* [*38*] and the very intent of *Rivers*.) This study therefore sought to determine the outcome of the judicial review process of any such cases.

Finally, information was sought concerning the overall outcome of any cases, including the disposition of criminal charges of the person treated. This study aims to add data from New York to address these questions regarding ECT, in the way that related research reports have sought to do regarding involuntary medication [*12,13,39*].

Methods

This investigation intended to include only subjects who met several criteria. First, subjects must have been adjudicated as 'incompetent to stand trial' and committed to a hospital for the restoration of competency to stand trial. New York statute mandates that misdemeanor offenders who are incompetent to stand trial must have their criminal charges dismissed. For this reason, a study in New York of criminal defendants who are to be restored to trial-competency must focus on felony offenders. More specifically, the sample is limited 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 psychiatric facility pursuant to New York State Criminal Procedure Law section 730.50. In New York, felony offenders who have not been indicted may be committed to a hospital for only a brief period of time, beyond which their charges must be dismissed.

The second criterion for inclusion in this study is refusal of ECT. The term 'refusal' is defined here very narrowly to include only those persons whose refusal has led clinicians to seek judicial permission for involuntary treatment. As noted elsewhere [*12,13,39*], this intentionally limits the study to cases of refusal that represent a small, but arguably most important, subset of all refusals. In other words, the current study does not seek to convey any information about any cases in which a patient refused ECT and in which the treating clinicians chose to comply with such a refusal. Instead, 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 a patient over the patient's objection. These applications are filed by psychiatrists in all state hospitals in New York, in accordance with the Office of Mental Health regulations that followed the 1986 *Rivers v. Katz* decision.

The period under study here begins with the inception of these regulations. Thus, this study aims to detect all indicted felony offenders who were incompetent to stand trial and for whom an application for involuntary treatment with ECT was filed between July, 1986 and July, 1991. In this five 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 [*40*]. Therefore this study was limited to these two facilities.

The design of this study includes a retrospective review of any applicable hospital charts and 'treatment over objection' application forms. In addition, follow-up data were obtained for several additional years. Provisions to ensure against breach of confidentiality were observed. This work was conducted in the context of a project authorized by an institutional review board.

Results

During the period under study, there was one application to the court for involuntary ECT among this group of patients. As reported elsewhere [*39*], during this period approximately 272.6 indicted felony offenders were committed for restoration of competency each year. Thus, out of a total of approximately 1365 such persons committed for treatment, one person who refused ECT was the subject of a request to the court for permission for involuntary treatment. It is not known how many patients, if any, either consented to receive ECT, or refused it and were not the subjects of attempts to overturn this refusal through an application to the court.

The characteristics and outcome of the single case will be described below. Limited identifying data are provided (and a pseudonym is used) in order to prevent breach of confidentiality.

Case

The single case involved a middle aged unmarried man, Mr. Brown, who had no prior history of psychiatric problems, violence, criminal activity or alcohol or drug use. Although he had always been a religious man, when he was in his 40s he rather suddenly became much more religiously preoccupied. During this period, he was arrested for the first time for forcibly removing a gate from the church that he regularly attended, and this first offense was quickly disposed of. One year later, he was again arrested for removing the same gate from the same church which he stated he did, "because God should be accessible at all times." This time he was found incompetent to stand trial and he was committed for treatment. Mr. Brown responded to injections of fluphenazine decanoate 100 milligrams a month, and he was deemed restored to competency. He went to criminal trial, was convicted of possession of burglary tools and sentenced to time served.

Soon after his release, Mr. Brown was arrested and sentenced to probation for 'criminal mischief.' While on probation for that charge, he grabbed a woman as she was exiting from a subway train and threw her to the ground. At that point, Mr. Brown exclaimed, "Don't wear a cross in your ear" and with that he pulled the woman's earring from her ear. He told the arresting police officer that God made him do this. He was arrested and indicted for robbery in the third degree, and he was found incompetent to stand trial.

Mr. Brown was criminally committed to a psychiatric facility for treatment for the purpose of being returned to the court once he was restored to competency to stand trial. He was noted early on to be undernourished and hypotensive due to frequent short-term periods of fasting, which he did based on his own particular religious beliefs. Mr. Brown also believed that he was an "Apostle of Christ" and that he therefore did not need, and indeed he refused, to discuss his charges with anyone. Mr. Brown also believed that his claim that he was on a divine mission would provide an adequate defense to his charges and that this would exculpate him.

Mr. Brown was initially diagnosed as suffering from schizophrenia. He refused oral medication. Over a period of several years, he received intramuscular injections of the long-acting haloperidol or fluphenazine decanoate, up to 100 milligrams a month, but he remained highly symptomatic. He continued to remain delusionally preoccupied concerning anyone who wore a cross. He believed that wearing a cross around one's neck or in earrings constituted a desecration and that he was on a divine mission to prevent this from occurring. He also specifically believed that God commanded him to attack others in order to provoke them to kill him so that he could become a martyr.

Indeed, Mr. Brown persisted over a period of years in physically attacking others in the hospital, especially people who wore a cross in what he believed was a sacrilegious way. Without warning, he assaulted other patients using an ashtray, or other blunt instruments. These episodes sometimes occurred as frequently as twice a week. On one occasion, he forcibly removed earrings from a visitor to the ward. Several other patients did indeed assault him in response to his attacks, on one occasion causing lacerations that required sutures.

The treatment team subsequently considered a working diagnosis of "major depression, with psychotic features" and recommended ECT. Mr. Brown refused ECT, and, according to the clinician's application to the court, he did not provide rational reasons for this refusal. The treating psychiatrist requested court permission to involuntarily administer up to 25 ECT treatments. A *Rivers* hearing was held, and Mr. Brown was found to lack the capacity to refuse the proposed treatment and that this treatment was in his best interests. With judicial authorization, a series of 20 ECT treatments were involuntarily administered. Mr. Brown failed to experience an adequate therapeutic response, and no further ECT was administered. There is no mention of any major side effects from these treatments.

When Mr. Brown's period of hospitalization reached three years his indictment was automatically dismissed. Such a dismissal is required by state statute whenever an incompetent defendant has been hospitalized for a period equal to two-thirds of the maximum time he could have received as a prison sentence had he been found guilty on the pending charges. Mr. Brown was then civilly committed.

Several years later, while still in the same psychiatric hospital, a working diagnosis of delusional disorder and obsessive-compulsive disorder led to a treatment trial using the combination of clomipramine, 175 milligrams a day, with haloperidol, 12 milligrams a day. On this regimen, Mr. Brown demonstrated increased periods of calm, an ability to request help when needed and improvement in his capacity to socialize with peers. For the next year, Mr. Brown successfully avoided committing any further violent acts in the hospital, although he remained religiously preoccupied, and stated that he would continue to attack people who wore a "cross in the wrong place," and that if he had the opportunity he would leave the hospital and go to a church. Later, Mr. Brown again required being placed in seclusion for aggression on the ward.

Discussion

The results of this study demonstrate that involuntary ECT to restore competency to stand trial did indeed occur in New York State during the five year period from 1986 to 1991. Thus, this issue is not moot. In fact, at least one other case has also taken place in the facilities under study, although subsequent to the period under study.

The relative infrequency of ECT cases in this context probably relates to the relative infrequency of mood disorders among incompetent defendants. Incompetent defendants typically suffer primarily from psychotic disorders. This may relate in turn to the fact that

psychotic disorders seem more likely to predispose an individual to act violently than do, for example, depressive disorders. Since ECT is generally a treatment reserved especially for the depressive disorders, it is not surprising that forced ECT arises infrequently among incompetent criminal defendants. In fact, what may be surprising is that it occurs at all, given the complex legal issues involved.

These legal questions seem to deserve re-examination in light of the 1993 Supreme Court decision in *Riggins v. Nevada.* That case, of course, dealt only with antipsychotic medication. However, it could easily be argued, as noted previously, that the Court's concerns in *Riggins* about adverse effects of medication apply, *a fortiori,* to the adverse effects of involuntary ECT treatments. ECT has, after all, been traditionally viewed by virtually all courts as at least as intrusive as medication. A person's refusal of ECT, therefore, almost certainly invokes equal if not much stronger liberty interests than does the refusal of medication.

A counter-argument, however, could also be advanced, as noted earlier, to justify forced ECT more readily in the pre-trial setting than to forcibly administer antipsychotic medication in this setting. This argument would be based on the likelihood that medication must typically be continued to be administered to a defendant at the time of the actual trial to maintain trial-competency in an otherwise severely psychotic individual. In contrast, ECT treatments, at least when administered to people with depressive disorders, are generally administered over a limited period of time, such as two weeks, and a defendant could therefore conceivably be treated with ECT and proceed to the actual trial without being subject to any coercive treatments at the time of trial. The problem with this argument, of course, relates to the possible residual adverse effects of the ECT that might still be present at the time of trial against the defendant's interests and wishes. In addition, the remissions induced by ECT are often short-lived and in many cases would not extend through a lengthy trial. The usual clinical practice of following a course of ECT with at least some form of medication for continuation therapy would in the present context eliminate many of the conceivable advantages of ECT over using medication alone.

Despite these uncertainties, it would seem to follow from the spirit of the *Riggins* decision that ECT should not be forcibly administered to a pre-trial defendant if the individual is 'competent' to refuse such treatment and if there exists no outweighing justification to override the refusal. This claim in turn raises two other issues, which are elaborated upon in greater detail in related articles [*12,13*] in the context of involuntary medication: defining various competencies, and defining criteria to justify involuntary psychiatric treatment.

The first issue pertains to the complexities in determining that someone who is 'incompetent to stand trial' may be 'competent' to refuse the very medication needed to restore trial-competency. This issue may be even more complicated in the context of ECT. Evaluating the competence of a person who is refusing ECT is sometimes especially difficult. In certain conditions, ECT may provide near miraculous relief to people suffering from extreme mental disorders. When ECT is life-saving in such circumstances, it has been [*40*] likened to the other commonly known therapeutic application of electricity in medicine, cardioversion of a stopped heart. The refusal of ECT in cases where it may be life-saving may in fact stem from conceptual distortions that are caused by an underlying mental disorder, and such an incompetent refusal might sometimes be justifiably overridden. At the same time, ECT has a particular side effect profile and it has retained a horrific image for some people ever since the days of its earliest use when anesthesia was not employed to prevent pain. For some people, the image conjured up under such circumstances has been [*40*] likened to society's other commonly known application of electricity to humans, the electric chair. Even such gut imagery might conceivably lead to a 'competent' refusal.

In the uncommon situation involving involuntary ECT to restore a criminal defendant to competency to stand trial, the issue of capital punishment may be more than just imagery. In the majority of states, which have capital punishment, the stakes of a criminal trial may indeed be life and death. Under such circumstances, the issue of forcing ECT to a pre-trial defendant raises the starkest questions. The problematic issues, however, are present as well in all criminal cases, and in states, like New York during the period of this study, which do not have a death penalty. The concern, as we have noted, centers on the potential adverse effects of ECT on the critically important memory capacities of a criminal defendant. This concern may represent a possible rational reason for a defendant to refuse ECT, beyond the other possible rational reasons which might be proffered in the ordinary clinical context.

At the very least, therefore, some of the questions that were elaborated upon in detail in articles about involuntary medication with incompetent defendants [*12,13,39*], concerning the criteria and process for overriding a refusal, should also be considered in this analogous situation with ECT. This includes, for example, the question of whether the criteria used in the *Rivers*-type hearings are sufficient in this context to override a treatment refusal. The *Rivers* criteria focuses on the patients' 'best interests.' It would seem that the criteria for overriding the refusal of ECT in the context of a criminal defendant should specifically include consideration of the effects of the proposed treatment on the defendant at a possible future criminal trial. Perhaps, an issue of such importance should be considered by the presiding judicial officer, *sua sponte,* and not be left to the initiative of a patient's particular legal advocate to argue. The legal calculus of *Rivers* may also be inadequate in this context because of the unique state interests involved here. Many court decisions have recognized the legitimate state interest in bringing a defendant to trial. In certain circumstances, this consideration could shift the balance of variables in the direction of potentially justifying forced treatments more readily with a criminal defendant than with a psychiatric patient in the civil setting.

The very limited data from the present study do not lend empirical support for conclusions on any of the numerous questions that forced ECT in this context gives rise to. However, the following recommendations, although not based on any data, could be viewed as deriving indirect support from the concerns expressed in the *Riggins* decision. They are offered here in the hope of generating further discussion and research of these issues.

- States that do not already require *judicial review* for the general administration of medication or ECT with patients who have not given their informed consent, should at the very least require judicial review before administering ECT to any pre-trial criminal defendants who have not given their informed consent.
- Such judicial review of involuntary ECT should consider not only what is in the person's *clinical* 'best interests' but also its likely *effects at a criminal trial.*
- *Special precautions* should be considered to minimize memory impairment, such as the use of unilateral or limited number of treatments; and independent consultants should be used to affirm its overall clinical appropriateness.

• The unique concerns inherent *in death penalty cases* would seem to call for eschewing the uncertainties inherent in forced ECT in such cases.

In summary, forced ECT is still being used to restore competency to stand trial. Although it may not occur frequently, lawmakers should include this issue amidst the legal analysis and the consideration of potential changes in law that are likely to follow the recent *Riggins* case. That case at the very least now invites, and perhaps demands, a reexamination of the due process owed to criminal defendants who refuse ECT. Further empirical research into this area might also be helpful in this regard. It might, for example, be of value to know the results of pre- and post-ECT memory assessments, specifically as they pertain to a pending legal case. Such a study might take place when ECT is being *voluntarily* administered, independent of a research protocol, to criminal defendants. However, even *voluntary* ECT in the context of a confined pre-trial defendant may raise real questions regarding the adequacy of informed consent and a potential need for the treating clinicians to notify defense counsel.

This study conveys the incidence of forced ECT among incompetent defendants in New York and it also conveys descriptive data about the one case that occurred in the study period. It would certainly be useful to know more about the actual experience of ECT among pre-trial criminal defendants in other localities. In the meantime, especially in the wake of *Riggins,* the development of additional safeguards beyond that which currently exists in many states seems appropriate. This study is an attempt to stimulate further consideration and research and perhaps legislative or judicial review of these issues.

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