SEEKING A SANE SOLUTION: REEVALUATING INTERESTS IN FORCIBLY MEDICATING CRIMINAL DEFENDANTS TO TRIAL COMPETENCY

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The forcible medication of incompetent criminal defendants involves complex legal and ethical issues. The Supreme Court has recognized the significant liberty interest of an individual to be free from unwanted medication. Governments can forcibly medicate non-dangerous detainees to trial competency only after proving the medication will further significant government interests, is medically appropriate, and is necessary. Because the standard for medicating a dangerous detainee is easier to meet, governments can alternatively medicate defendants to competency upon a showing of dangerousness. This Note discusses the different levels of protection afforded to dangerous and non-dangerous detainees and the implications of these two standards. It reevaluates liberty and government interests in light of the likely outcomes of a decision under current doctrine and concludes that preserving the right of a mentally disordered person to refuse treatment should not be balanced merely against the government interest in bringing the accused to trial, but also against the government interests in alleviating suffering, respecting life, and the personal autonomy sacrificed to the disease by refusing treatment.

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TABLE OF CONTENTS

INTRODUCTION

Millions of Americans suffer with symptoms of mental illness.[1] Many seek treatment, but some are so affected they do not realize the need for help. State laws provide for the treatment of non-incarcerated mentally ill persons who are a danger to themselves or others and are unable to make rational and informed decisions about treatment.[2] A person in this condition lacks the ability to understand that he is ill and is considered incompetent to refuse medication. It is possible, however, to be competent to refuse medication but incompetent to stand trial. This Note focuses on the relatively narrow class of mentally ill persons who are competent enough to refuse treatment, but are nevertheless considered incompetent to stand trial.

Every year, thousands of mentally ill persons face criminal charges. Experts estimate that between 50,000 and 60,000 criminal defendants go through evaluations each year to determine trial competency.[3] Courts find approximately

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1. *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., RESULTS FROM THE 2006 NATIONAL SURVEY ON DRUG USE AND HEALTH: NATIONAL FINDINGS 84 (2006). An estimated 11.3% of the adult population was believed to have serious psychological distress, defined as having symptoms at a level known to be indicative of having a mental disorder. *Id.* at 83–84.

2. *See, e.g.*, ALA. CODE § 22-52-10.4 (2012); ALASKA STAT. § 47.30.755(a) (2012); ARIZ. REV. STAT. ANN. § 36-540(A) (2012).

3. Richard J. Bonnie & Thomas Grisso, *Adjudicative Competence and Youthful Offenders*, *in* YOUTH ON TRIAL: A DEVELOPMENTAL PERSPECTIVE ON JUVENILE JUSTICE 73,

10–30% of those evaluated incompetent for trial.[4] While no clinical diagnosis alone sufficiently indicates incompetence, a schizophrenia diagnosis is strongly associated with competence-impairment in criminal adjudications.[5] This Note will focus on criminal defendants suffering from schizophrenia and other related psychotic disorders.

The test for competency to stand trial is whether the defendant is able to understand the proceedings against him and assist in his defense.[6] Competency must be satisfied because the conviction of an incompetent person violates Due Process.[7] Either party may request a hearing to determine competency.[8] In the federal system, if the court finds the defendant incompetent to stand trial, it refers him to the custody of the Attorney General for treatment and a determination of whether he might be restored to competency.[9] Although the defendant has a right to refuse any treatment offered, he may be medicated against his will if such a procedure is "reasonably related to legitimate penological interests."[10] These interests include protecting inmates and staff from a dangerous detainee. The

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78 (Thomas Grisso & Robert G. Schwartz eds., 2000); Jennifer L. Skeem et al., *Logic and Reliability of Evaluations of Competence to Stand Trial*, 22 LAW & HUM. BEHAV. 519, 519 n.4 (1998) (stating that approximately 49,611 defendants were evaluated for competency to stand trial in 1993).

4. THOMAS GRISSO, EVALUATING COMPETENCIES: FORENSIC ASSESSMENTS AND INSTRUMENTS 70 (2d. ed. 2003); Ronald Roesch et al., *Defining and Assessing Competency to Stand Trial*, *in* THE HANDBOOK OF FORENSIC PSYCHOLOGY 327, 332 (Irving B. Weiner & Allen K. Hess eds., 2d ed. 1999); *see also* Gianni Pirelli et al., *A Meta-Analytic Review of Competency to Stand Trial Research*, 17 PSYCHOL. PUB. POL'Y & L. 1, 3 (2011) ("Base rates from competency referrals and ultimate decisions of competency have been found to vary between and within jurisdictions and settings, but the modal jurisdictional estimate of incompetency for referred defendants has been thought to be 20%.").

5. Norman Poythress, et al., MACARTHUR RESEARCH NETWORK ON MENTAL HEALTH & THE LAW, THE MACARTHUR ADJUDICATIVE COMPETENCY STUDY (May 2004), *available at* http://www.macarthur.virginia.edu/adjudicate.html.

6. 18 U.S.C. § 4241(a) (2012); *see* Drope v. Missouri, 420 U.S. 162, 171 (1975) ("[A] person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial."); Dusky v. United States, 362 U.S. 402, 402 (1960) (stating that the test for competency to stand trial "must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him").

7. *See* Pate v. Robinson, 383 U.S. 375, 384–85 (1966) (holding that the failure of the state to conduct a competency hearing despite the defendant not requesting it violated due process; an incompetent defendant cannot "waive" his right to have his capacity determined before trial); Bishop v. United States, 350 U.S. 961, 961 (1956) (mem.) (remanding appeal of murder conviction to district court for determination of competency); United States v. Knohl, 379 F.2d 427, 434 (2d Cir. 1967) ("[A] defendant who has been convicted while he is incompetent to stand trial has been deprived of due process.").

8. 18 U.S.C. § 4241(a).

9. *Id.* § 4241(d).

10. Washington v. Harper, 494 U.S. 210, 223 (1990) (quoting Turner v. Safley, 482 U.S. 78, 89 (1987)).

medication administered must also be in the defendant's medical interest.[11] The court defers to the judgment of the penological institution to regulate dangerous inmates and the court applies a reasonableness standard of review.[12]

If an inmate or detainee is not dangerous, and the government seeks to forcibly medicate the defendant solely for the purpose of rendering him competent to stand trial, the standard is much stricter. It requires: (1) important governmental interests that are (2) significantly furthered by involuntary medication, which is (3) necessary to further those interests, and is (4) medically appropriate.[13] The Supreme Court has suggested that meeting this four-part standard might be difficult.[14] The Court found "strong reasons" to determine whether forced administration of drugs can be justified on the grounds of dangerousness *before* turning to the question of trial competency.[15] One reason offered by the Court is that an inquiry into forced medication for purposes related to an individual's dangerousness is usually more "objective and manageable."[16]

Because the standard of review for forced medication on the basis of danger is reasonableness, and detention facilities determine danger instead of courts, the possibility exists that the government will render a detainee competent for trial by forcibly medicating on the alternative basis of dangerousness. Some legal commentators have noted this discrepancy and suggested the courts move to a single strict scrutiny standard for authorizing forced medication in the pretrial context.[17] This could resolve some of the problems with the two standards, but a complete solution will require a deeper inquiry into the meaning of autonomy, other important government interests, and the expected outcome of allowing forced medication or refusal.

This Note explores the liberty interest in being free from unwanted medication and the practical effect of the two different standards on an individual's rights. Part I examines the development of the standards for forced medication on the bases of dangerousness and rendering detainees competent for trial. It also

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11. *Id.* at 227.

12. *Id.* at 223–24; *Turner*, 482 U.S. at 85–91; O'Lone v. Estate of Shabazz, 482 U.S. 342, 349–53 (1987).

13. Sell v. United States, 539 U.S. 166, 180–81 (2003). This standard might sound like an intermediate test because the Court refers to a requirement that government interests be merely "important" as opposed to "compelling." On this point, consider the articulation of the compelling state interest test in *Boerne v. Flores*, 521 U.S. 507, 513 (1997), and the description of an intermediate test in *United States v. Virginia*, 518 U.S. 515, 571 (1996). However, the Court's reference to the difficulty in ever meeting this test and the inclusion of a least restrictive alternative and a substantial means–ends requirement, suggests much more than the gender intermediate test.

14. *Sell*, 539 U.S. at 180.

15. *Id.* at 182.

16. *Id.* The Court also noted that medical experts may find it easier to provide an opinion whether a particular drug is medically appropriate to control dangerous behavior, in light of its side effects, than to "balance harms and benefits related to the more quintessentially legal questions of trial fairness and competence." *Id.*

17. *See infra* Part II.

explores the inherent tension between these standards and the professional judgment standard, which requires courts to "show deference to the judgment exercised by a qualified professional" in determining what treatment is appropriate.[18] Part II analyzes the application of the two standards and the possibility of a dangerousness "loophole." Finally, Part III evaluates the liberty interest of autonomy, the government interest in bringing a person accused of a serious crime to trial, and other government interests, in light of possible outcomes of medicating a criminal defendant to trial competency.

Part III argues further that an analysis of state and individual interests in a forced medication decision should include possible outcomes. On the one hand, involuntary medication of a criminal defendant charged with a capital crime could have the effect of making a person well only to be executed. This creates difficult ethical questions for the treating physician whose duty is generally accepted to be "first, do no harm."[19] Other ethical questions arise when the physician has the ability to alleviate suffering but is not permitted to treat the individual because the patient has refused treatment. Even if the death penalty is a possibility, the effects of untreated schizophrenia may still be worse than the threat of execution. Common symptoms of untreated schizophrenia include delusions, hallucinations, and severe depression.[20] These symptoms can be so severe that between 18–55% of those afflicted with schizophrenia attempt suicide, and roughly 10–13% succeed.[21]

Ultimately, even if a criminal defendant is found guilty and sentenced to death, his likelihood of actually being executed is very low.[22] During the period from 1977 to 2009, 41% of prisoners facing death were removed from death row

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18. Youngberg v. Romeo, 457 U.S. 307, 322 (1982).

19. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 113 (5th ed. 2001). Beauchamp and Childress recognize four basic moral principles in biomedical ethics: (1) respect for autonomy, (2) non-malfeasance ("Above all [or first], do no harm"), (3) beneficence, and (4) justice. *Id.* at 12.

20. AM. PSYCHIATRIC ASS'N., DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS § 295 (4th ed., text revision 2000) [hereinafter DSM-IV-TR]; *see also* Sidney Zisook et al., *Depressive Symptoms in Schizophrenia*, 156 AM. J. PSYCHIATRY 1736, 1741 (1999) (finding depressive symptoms to be frequent and severe in patients with schizophrenia). Depression may be a byproduct of schizophrenia's psychotic symptoms or an independent aspect of schizophrenia. *Id.* at 1742.

21. *See, e.g.*, NIMH, SCHIZOPHRENIA 5 (2009), *available at* www.nimh.nih.gov/health/publications/schizophrenia/schizophrenia-booket-2009.pdf; Julie A. Kreyenbuhl et al., *Circumstances of Suicide Among Individuals with Schizophrenia*, 58 SCHIZOPHRENIA RES. 253, 253 (2002); Samuel G. Siris, *Suicide and Schizophrenia*, 15 J. PSYCHOPHARMACOLOGY 127, 127 (2001).

22. *See* TRACY L. SNELL, BUREAU OF JUSTICE STATISTICS, CAPITAL PUNISHMENT, 2009, at 1 (2010). Between 1977 and 2009, only 14.6% of those sentenced to death were executed. Convictions or sentences were overturned for 36.2% of death row inmates, 4.5% had their sentences commuted, 5.1% died, and 39.1% remain under sentence of death. *Id.* at 21.

by overturned convictions or commuted sentences.[23] The convicts who are executed have been in prison for an average of over 14 years.[24]

In jurisdictions without a death penalty or where statutory provisions allow for findings of "guilty but insane," the balance of interests shifts. When a death sentence is not a possibility and the rate of spontaneous recovery is low—as with schizophrenia—there are two likely outcomes. The first is adjudication and a possible prison sentence with medication and treatment. The second is confinement in a detention facility where the defendant refuses medication, remains incompetent to stand trial, and suffers with the symptoms of mental illness.

This Note concludes that preserving the right of a mentally disordered person to refuse treatment should not be balanced merely against the government interests in bringing the accused to trial but also against government interests in alleviating suffering and respecting life. The liberty interest in refusing medication must also be balanced against the personal autonomy sacrificed to the disease if the person refuses treatment.

I. LIBERTY INTEREST IN BEING FREE FROM FORCED MEDICATION

The individual's right to refuse medical treatment is rooted in the common law right to be free from unwanted bodily intrusion.[25] This right is reflected in the tort law doctrine of informed consent.[26] A patient has the right to refuse treatment even if it means certain death or suffering, as long as he is competent.[27] Courts have held that incompetence for trial is not dispositive of a patient's right to refuse medical treatment.[28]

A. Right of Pretrial Detainee to Refuse Treatment for Mental Illness

Traditionally, mentally ill persons were considered incompetent to make decisions, so the common law doctrine of informed consent did not apply to them.

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23. *Id.*

24. *Id.* at 14. The average time for those executed in 2009 was 169 months (or approximately 14 years and 1 month). This time is calculated from the most recent sentencing date. *Id.*

25. United States v. Charters (*Charters I*), 829 F.2d 479, 490 (4th Cir. 1987), *rev'd and remanded*, 863 F.2d 302 (4th Cir. 1988) (en banc); *see also* Union Pac. Ry. v. Botsford, 141 U.S. 250, 251 (1891) ("No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others . . . .").

26. *Charters I*, 829 F.2d at 491.

27. Thor v. Superior Court, 855 P.2d 375, 381 (Cal. 1993) (right to refuse does not turn on wisdom of decision because health care decisions intrinsically concern a "subjective sense of well-being"); *see also* Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . . .").

28. *See* Scott v. Plante, 532 F.2d 939, 946 (3d Cir. 1976), *vacated and remanded*, 458 U.S. 1101 (1982); Woodland v. Angus, 820 F. Supp. 1497, 1502 n.5 (D. Utah 1993).

Patients seeking the right to refuse treatment turned to the Constitution. Federal courts have found a constitutional basis for the right to refuse treatment in the First Amendment,[29] the Eighth Amendment,[30] and in the Due Process Clause of the Fifth and Fourteenth Amendments.[31] The Supreme Court has specifically ruled on the issue of forced medication for mentally ill prisoners and detainees in three cases: *Washington v. Harper*,[32] *Riggins v. Nevada*,[33] and *Sell v. United States*.[34]

In *Washington v. Harper*, the Court first examined a mentally ill prison inmate's interest in refusing antipsychotic medication and concluded that an inmate has a "significant liberty interest" in refusing medication under the Fourteenth Amendment.[35] Walter Harper alleged that the government violated his rights under the Due Process Clause by forcibly administering antipsychotic drugs without a judicial hearing.[36] Harper was sentenced to prison for robbery in 1976 and, while there, he consented to the administration of antipsychotic drugs to treat his mental illness.[37] He was paroled in 1980 on the condition that he would remain in treatment.[38] He continued treatment while on parole and was later civilly committed to the Western State Hospital.[39] After assaulting two nurses at the hospital, Harper was sent back to prison where he refused treatment.[40] The Washington state policy allowed forced medication "only if [the inmate] (1) suffer[ed] from a 'mental disorder' and (2) [was] 'gravely disabled' or pose[d] a 'likelihood of serious harm' to himself, others, or their property."[41] The Court evaluated the procedural and substantive aspects of the state policy and held that although Harper had a significant liberty interest in refusing the medication,[42] the

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29. *See Charters I*, 829 F.2d at 492 (finding psychotropic medication "has the potential to allow the government to alter or control thinking and thereby to destroy the independence of thought and speech"); Bee v. Greaves, 744 F.2d 1387, 1393–94 (10th Cir. 1984) ("Antipsychotic drugs have the capacity to severely and even permanently affect an individual's ability to think and communicate."); Lojuk v. Quandt, 706 F.2d 1456, 1465 (7th Cir. 1983) (discussing several cases where courts have found compulsory drug treatment an invasion of First Amendment interests); *Scott*, 532 F.2d at 946.

30. *See* Nelson v. Heyne, 491 F.2d 352, 355–57 (7th Cir. 1974); Knecht v. Gillman, 488 F.2d 1136, 1139–40 (8th Cir. 1973); Mackey v. Procunier, 477 F.2d 877, 878 (9th Cir. 1973).

31. *See, e.g.*, Benson v. Terhune, 304 F.3d 874, 876, 884–86 (9th Cir. 2002); United States v. Weston, 255 F.3d 873, 876 (D.C. Cir. 2001); United States v. Brandon, 158 F.3d 947, 961 (6th Cir. 1998).

32. 494 U.S. 210 (1990).

33. 504 U.S. 127 (1992).

34. 539 U.S. 166 (2003).

35. 494 U.S. at 221–22.

36. *Id.* at 217.

37. *Id.* at 213. It is unclear what Harper's diagnosis was at that time. Later he was diagnosed with manic-depressive disorder, schizo-affective disorder, and schizophrenia. *See id.* at 214 n.2.

38. *Id.* at 213–14.

39. *Id.* at 214

40. *Id.*

41. *Id.* at 215 (quoting WASH. REV. CODE § 71.05.020 (2012)).

42. *Id.* at 221.

Due Process Clause permits the state to forcibly treat an inmate who is seriously ill if that inmate is dangerous to himself or others and the treatment is in his best medical interest.[43] The Court also held that procedural Due Process did not require a judicial hearing and that the inmate's interests were "perhaps better served" by allowing medical professionals to decide to medicate instead of the judge.[44]

In the prison context, the state's interests in safety and security are strong. The Court held in *Turner v. Safley* and *O'Lone v. Estate of Shabazz* that the standard for determining the validity of a prison regulation that may infringe on an inmate's constitutional rights was whether the regulation was "reasonably related to legitimate penological interests."[45] In *Harper v. State*, the Washington Supreme Court applied a compelling state interest test to the state's forcible medication policy, distinguishing the interest in refusing medication from the First Amendment issues involved in *Turner* and *Shabazz*.[46] The U.S. Supreme Court held that the Washington Supreme Court erred in refusing to apply the standard of reasonableness when forcibly medicating on the basis of danger.[47]

The Court subsequently examined the forced medication of a pretrial detainee in *Riggins*.[48] In this case, the petitioner was awaiting trial on charges of murder and robbery.[49] A few days after being taken into custody, Riggins told a psychiatrist that he was hearing voices and that he had previously been successfully treated with an antipsychotic drug.[50] The psychiatrist prescribed the drug and Riggins took it voluntarily.[51] The district court granted Riggins a competency hearing, and after three psychiatrists examined him, the court found him to be legally sane and competent to stand trial.[52] Riggins then moved for an order to suspend administration of the antipsychotic drug on the grounds that it infringed his freedom.[53] He claimed that the drug's effects on his demeanor and mental state would deny him due process, because Riggins's insanity defense was

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43. *Id.* at 227.

44. *Id.* at 231.

45. Turner v. Safley, 482 U.S. 78, 89 (1987); O'Lone v. Estate of Shabazz, 482 U.S. 342, 349 (1987).

46. Harper v. State, 759 P.2d 358, 364 & n.9 (1988), *rev'd*, 494 U.S. 210 (1990).

47. *See Harper*, 494 U.S. at 223.

48. Riggins v. Nevada, 504 U.S. 127 (1992).

49. *Id.* at 129.

50. *Id.*

51. *Id.* Riggins was initially prescribed 100 mg of Mellaril per day, which was gradually increased to a dosage of 800 mg per day. *Id.*

52. *Id.* at 129–30. Two of the three psychiatrists, including Riggins's former treating psychiatrist, found him competent. *Id.* at 130. A third psychiatrist found Riggins incompetent. *Id.* Riggins was taking 450 mg of Mellaril per day at the time of his evaluations. *Id.* Side effects of Mellaril included a "sedation-like effect" and, as reported by Dr. Jurasky who testified at trial, "[d]rowsiness, constipation, perhaps lack of alertness, changes in blood pressure. . . . Depression of the psychomotor functions. If you take a lot of it you become stoned for all practical purposes and can barely function." *Id.* at 143 (Kennedy, J., concurring).

53. *Id.* at 130 (majority opinion).

premised on showing jurors his "true mental state."[54] The district court denied Riggins's motion to terminate medication and ordered that he continue to receive the medication throughout the trial.[55] Riggins's insanity defense—bolstered by his own testimony—failed.[56] He was convicted and sentenced to death.[57] The Nevada Supreme Court upheld his conviction, holding that expert testimony about the effects of the drug was sufficient to inform the jury of how Riggins's demeanor and testimony were affected.[58]

The U.S. Supreme Court found Riggins was forcibly medicated from the time the district court denied his motion to suspend medication.[59] The Court stated that the Fourteenth Amendment affords at least as much protection to pretrial detainees as it does to prisoners.[60] In balancing the state's interests against Riggins's interests, the Court held that the district court erred in allowing the forced medication to continue "without making *any* determination of the need for this course or *any* findings about reasonable alternatives."[61] The state of Nevada had argued in the district court that the continued administration of the antipsychotic was necessary to ensure Riggins could be tried.[62] The district court failed to acknowledge Riggins's liberty interest in freedom from unwanted drugs, and instead balanced the risk of his defense being prejudiced by the drug's effects against the possibility of Riggins becoming incompetent and untriable without the medication.[63] Because the district court failed to balance Riggins's liberty interests against the interests of the state, the Supreme Court did not determine what substantive standards would be required in the pretrial or trial setting.[64] The Court did suggest, however, that Nevada would have satisfied due process if it had demonstrated that treatment with antipsychotic medication was "medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others."[65]

In the concurring opinion, Justice Kennedy saw the question as "whether the State's interest in conducting the trial allows it to ensure the defendant's competence by involuntary medication, assuming of course there is a sound medical basis for the treatment."[66] Justice Kennedy saw a serious concern in

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54. *Id.*
55. *Id.* at 131.
56. *Id.*
57. *Id.*
58. Riggins v. State, 808 P.2d 535, 538–39 (Nev. 1991), *rev'd*, 504 U.S. 127 (1992).
59. *Riggins*, 504 U.S. at 133. The Court also assumed the medication was medically appropriate. *Id.*
60. *Id.* at 135; *see* Bell v. Wolfish, 441 U.S. 520, 545 (1979) (pretrial detainees are entitled to at least the same constitutional rights as prisoners).
61. *Riggins*, 504 U.S. at 136–37.
62. *Id.* at 130.
63. *Id.* at 136–37.
64. *See id.* at 136.
65. *Id.* at 135.
66. *Id.* at 140 (Kennedy, J., concurring).

forcibly medicating a mentally ill defendant to competence because of the effect the medication may have on the defendant's ability to assist counsel and to effectively present himself before a jury.[67] In Kennedy's view, competence to stand trial would include a showing by the state in every case that there is no risk of the medication impairing or altering "the defendant's capacity or willingness to react to the testimony . . . or to assist his counsel."[68]

In *Sell v. United States*, the Court finally took up the question of forcibly medicating a mentally ill criminal defendant solely for the purpose of rendering him competent to stand trial.[69] Charles Sell, a dentist with a history of mental illness, was hospitalized and treated with antipsychotics on multiple occasions.[70] In 1997, Sell was charged with submitting false insurance claims.[71] A Federal Magistrate Judge found Sell competent and released him on bail.[72] The Magistrate held a bail revocation hearing after the government claimed that Sell tried to intimidate a witness.[73] At the hearing, Sell appeared "totally out of control," shouted insults and racial slurs, and spit in the judge's face.[74] The Magistrate revoked Sell's bail.[75]

A grand jury later indicted Sell for attempting to murder both the FBI agent who had arrested him and a former employee who planned to testify against him.[76] The Magistrate reconsidered Sell's competency, and after an examination at the Federal Prisoners Medical Center ("FPMC"), determined he was incompetent for trial.[77] Sell was detained at the FPMC for treatment and to determine whether he might become competent.[78] The FPMC staff recommended that Sell take antipsychotic medication, but he refused.[79] The FPMC reviewing psychiatrist determined that Sell was "mentally ill and dangerous" and that involuntary medication was necessary to both treat the illness *and* to render Sell competent for trial.[80] The "dangerousness" was evidenced by Sell's threats and delusions outside of the facility.[81]

After an administrative review upheld the FPMC reviewing psychiatrist's decision to forcibly medicate, Sell filed a court motion challenging the forced medication.[82] The Magistrate found that the government had shown that Sell was a

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67. *Id.* at 140–41.
68. *Id.* at 141.
69. 539 U.S. 166 (2003).
70. *Id.* at 169–70.
71. *Id.* at 170.
72. *Id.*
73. *Id.*
74. *Id.*
75. *Id.*
76. *Id.*
77. *Id.* at 170–71.
78. *Id.* at 171.
79. *Id.*
80. *Id.* at 171–72.
81. *Id.* at 172.
82. *Id.*

danger to himself or others based in part on an incident that occurred after the administrative proceedings.[83] Next, the district court reviewed the record and found that the Magistrate's finding of dangerousness was "clearly erroneous" but affirmed the order allowing forced medication on the basis that the drugs "represent the only viable hope of rendering the defendant competent to stand trial."[84] The court of appeals affirmed the district court ruling, finding that Sell's behavior was at most an "inappropriate familiarity and even infatuation" with a nurse and not evidence of danger to himself or others.[85] The court of appeals concluded, however, that the "government ha[d] an essential interest in bringing a defendant to trial," that the treatment was medically appropriate, and that there were no less intrusive means to achieve this interest.[86]

Building on the framework of *Harper* and *Riggins*, the Supreme Court in *Sell* reaffirmed that an individual has a constitutionally protected liberty interest in avoiding unwanted medication, but held that the important government interest in bringing a defendant facing serious criminal charges to trial could support forcibly medicating that defendant to competency.[87] The Court devised a four-prong standard that requires: (1) important governmental interests that are (2) significantly furthered by involuntary medication, which is (3) necessary to further those interests, and is (4) medically appropriate.[88] Involuntary medication must significantly further the government's important interest by being substantially likely to render the defendant competent without substantially creating side effects that will interfere significantly with the defendant's ability to assist counsel in his defense.[89] The court must also find that the involuntary medication is necessary to further those interests, meaning that any less intrusive treatments are unlikely to achieve substantially the same results.[90] Finally, the court must conclude that administering the drug is medically appropriate and in the patient's best interest in light of his medical condition.[91]

In *Sell*, the Court found that the decision to medicate the defendant was made not solely on the basis of rendering him competent for trial, but to mitigate dangerousness *and* to render him competent.[92] Because the experts in the hearing before the Magistrate focused on Sell's dangerousness, they did not address the issue of how the medication's side effects might impact Sell's ability to assist in

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83. *Id.* The incident involved Sell approaching a nurse, suggesting he was in love with her and criticizing her for having nothing to do with him. *Id.* at 172–73.

84. *Id.* at 174. The district court also gave weight to the fact that the involuntary medication would serve the government's interest in adjudicating guilt or innocence on several serious charges. *Id.*

85. *Id.*

86. *Id.* (quoting United States v. Sell, 282 F.3d 560, 568 (8th Cir. 2002)).

87. *Id.* at 178–80.

88. *Id.* at 180–81.

89. *Id.* at 181; *see supra*, notes 66–68 and accompanying text.

90. *Sell*, 539 U.S. at 181.

91. *Id.*

92. *Id.* at 185.

his defense.[93] The lower courts also did not weigh the fact that Sell had already been confined for a long period of time, which moderates the importance of the government interest in prosecution.[94] Accordingly, the case was remanded.[95]

B. Applying the Standard to Render Defendants Competent

Several circuits have applied the *Sell* framework, and reviewing courts have applied the Supreme Court decision in *Riggins v. Nevada*[96] to require the government to prove each of the four *Sell* factors by clear and convincing evidence.[97] Courts have determined the question of whether the government interest is important to be a legal issue, which is reviewed de novo.[98]

1. Important Government Interest

The first prong in the *Sell* analysis requires that forcibly medicating a detainee for the sole purpose of making him competent must serve the important government interest of bringing the accused to trial.[99] This interest is met if the crime is "serious."[100] In *Sell*, the Court gave little guidance as to what constitutes a serious crime other than that it may be "against the person or . . . against property."[101] No circuit court has interpreted the serious crime designation as allowing a categorical analysis,[102] but they have interpreted the reference to crimes against property and persons as being merely illustrative of the types of crimes serious enough to make the government interest in bringing the accused to trial an important one.[103]

In other contexts, however, the Supreme Court has given guidance as to what constitutes a "serious" crime.[104] In assessing what crimes are serious enough to warrant Sixth Amendment protections, the Court stated that the penalty authorized for a crime is relevant in determining whether it is serious.[105] Circuit courts have looked to the possible outcome of a criminal case to determine if the

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93. *Id.*
94. *Id.* at 186.
95. *Id.*
96. 504 U.S. 127, 133–36 (1992).
97. *See* United States v. White, 620 F.3d 401, 410 (4th Cir. 2010); United States v. Green, 532 F.3d 538, 561 (6th Cir. 2008); United States v. Bradley, 417 F.3d 1107, 1114 (10th Cir. 2005); United States v. Gomes, 387 F.3d 157, 160 (2d Cir. 2004).
98. *Green*, 532 F.3d at 546; United States v. Hernandez-Vasquez, 513 F.3d 908, 915–16 (9th Cir. 2008); *Bradley*, 417 F.3d at 1113–14; *Gomes*, 387 F.3d at 160.
99. 539 U.S. at 180.
100. *Id.*
101. *Id.*
102. *Hernandez-Vasquez*, 513 F.3d at 917.
103. *See id.* at 917–18; *Green*, 532 F.3d at 547–51; United States v. Evans, 404 F.3d 227, 237 (4th Cir. 2005) (finding it proper to focus on a statute's maximum authorized penalty to see if a crime is "serious").
104. *See* Duncan v. Louisiana, 391 U.S. 145, 159–60 (1968) (deciding what crimes are considered "serious" in assessing Sixth Amendment rights).
105. *Id.* at 159.

crime is serious, but are divided on whether the statutory maximum penalty or the Sentencing Guidelines in the particular case should be used.[106] Courts have upheld even nonviolent crimes as "serious"—and supportive of an important government interest—if the possible sentence is substantial.[107]

The Supreme Court noted in *Sell* that courts must consider the facts of each case in evaluating the strength of the government interest.[108] Special circumstances, such as the possibility of a lengthy future confinement or a defendant who has already been confined for a significant amount of time, can mitigate the importance of the government interest.[109] In *United States v. Moruzin*, a federal district court held that although the charge of armed robbery was a serious crime, the government interest in prosecuting the crime was "tempered by by the strong likelihood" that the defendant would be civilly confined if he continued to refuse medication.[110] Although Moruzin was not considered a danger to himself or others while in the secure health unit—which would have supported forced medication on *Harper*-type grounds—the district court found that if he was released, he could present "a substantial risk of bodily injury to another person or serious damage to property of another."[111] This risk would support civil commitment.[112] The district court denied the government's motion to forcibly medicate Moruzin because the government interest was weakened by the strong likelihood that if Moruzin continued to refuse medication, he would be civilly committed for an extended period of time.[113]

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106. The Sixth and Fourth Circuits looked to maximum statutory penalties to determine seriousness. *See, e.g.*, *Green*, 532 F.3d at 546 (concluding the Sentencing Guidelines are not an objective measure of a crime's seriousness); *Evans*, 404 F.3d at 237. The Ninth Circuit has relied on Sentencing Guidelines to help determine seriousness. *See, e.g.*, *Hernandez-Vasquez*, 513 F.3d at 918–19. The Tenth Circuit has looked at both maximum statutory penalties and the Sentencing Guidelines to determine seriousness. *See, e.g.*, United States v. Valenzuela-Puentes, 479 F.3d 1220, 1226 (10th Cir. 2007).

107. *See Valenzuela-Puentes*, 479 F.3d at 1226–27. Valenzuela-Puentes was charged with illegal reentry into the United States after deportation due to an aggravated felony conviction. *Id.* at 1221. He argued that his alleged crime was not serious because "[n]o specific intent is required[, n]o victims are involved[, n]o threatening or violent conduct is involved[; and t]ypically no one is put in danger or at risk except the defendant himself[.]" *Id.* at 1226. It failed because the charge carried a statutory maximum penalty of 20 years and a likely sentence, if he pleaded guilty, of seven to eight years. *Id.*

108. Sell v. United States, 539 U.S. 166, 180 (2003).

109. *Id.*

110. 583 F. Supp. 2d 535, 546 (D.N.J. 2008).

111. *Id.* at 546 (quoting 18 U.S.C. § 4246(a) (2012)).

112. *See* 18 U.S.C. § 4246(a). This statute authorizes civil commitment of a person who, because of his mental condition, has had criminal charges dismissed. *Id.* The person is entitled to a hearing in which the court will determine, by clear and convincing evidence, if he is presently suffering from a mental illness or defect which would create a "substantial risk" of bodily injury or property damage to another. *Id.*

113. *Moruzin*, 583 F. Supp. 2d at 546, 552. The district court also found evidence supporting the other three prongs of the *Sell* analysis that were lacking. *Id.*

In *United States v. White*, the Fourth Circuit held that special circumstances mitigated the government's interest in prosecuting a serious crime to the point that forcibly medicating the defendant was not permitted.[114] First, by the time White was rendered competent—and found guilty—she would have already been confined for a "significant" amount of time in relation to her probable sentence.[115] The court did not limit its analysis to whether the defendant had already been confined for a significant amount of time or would likely face a substantial civil confinement, but also looked to the nature of White's alleged crimes: [116] credit card fraud, identity theft, and conspiracy to commit fraud.[117] The court held that because the alleged crimes were nonviolent, prosecution would not help safeguard the defendant's alleged victims.[118] Accordingly, the diminished government interest did not justify forced medication.[119]

Courts are most likely to find important government interests, which could support forced medication, in cases involving violent crimes where the defendant may not face a lengthy civil commitment if he continues to refuse medication.

2. Significantly Furthered

In order to prove that forced medication will significantly further the government's important interest, the government must prove the drug will be substantially likely to render the defendant competent for trial without creating side effects that prejudice his right to a fair trial.[120] Side effects, such as restlessness, nervousness, or drowsiness can affect fair trial rights by altering the way a defendant (or his reactions) appear to a jury.[121] The defendant's ability to assist in his defense is also impaired when he is medicated with a drug that dulls cognition.[122] The specific drug to be administered and the specific side effects of that drug must be considered in a *Sell* hearing.[123]

Determining the first element of this prong—whether the proposed drug will make a defendant competent—requires the court to rely on medical experts. Medical experts do not have to be certain the drug will be effective, but must believe that it is substantially probable to achieve its purpose.[124] The record must contain evidence of the medication's effectiveness, which will clearly convince the

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114. 620 F.3d 401, 410 (4th Cir. 2010).
115. *Id.* at 414.
116. *Id.* at 419.
117. *Id.* at 404.
118. *Id.* at 419.
119. *Id.* at 419–22.
120. Sell v. United States, 539 U.S. 166, 181 (2003).
121. *See* Riggins v. Nevada, 504 U.S. 127, 142–43 (1992) (Kennedy, J., concurring).
122. *Id.*
123. 539 U.S. at 181. ("The specific kinds of drugs at issue may matter . . . [because d]ifferent kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success.").
124. United States v. Payne, 539 F.3d 505, 508–10 (6th Cir. 2008).

court it will restore the individual to competency.[125] Courts have found a proposed treatment plan is substantially likely to restore an individual to competency when that individual has been previously rendered competent by the same medication,[126] or when experts testify that the medication has a high rate of success with similar individuals.[127] The state does not meet this burden when the likelihood of rendering a defendant competent is statistically low.[128]

The second element that the state must satisfy is that the forced medication be substantially *unlikely* to interfere with the defendant's right to a fair trial.[129] This analysis focuses on the specific medication to be administered and its side effects. Antipsychotic medications, for example, may cause movement-related side effects including rigidity, tremors, or muscle spasms. With long-term use, there is danger of a condition called tardive dyskinesia, which causes uncontrolled muscle movements, generally around the mouth.[130] Movement-related side effects are reduced with second-generation antipsychotics, but these "atypical" drugs have an increased likelihood of major weight gain.[131] Both typical and atypical antipsychotics can cause sedation effects and drowsiness.[132] At all stages of a trial, the defendant's behavior, facial expressions, and emotional responses have an impact on the outcome.[133] If he takes the stand, an involuntarily medicated defendant's demeanor may affect his credibility, persuasiveness, and ability to convey remorse or compassion.[134] Side effects of antipsychotic medications may

125. *See* United States v. Valenzuela-Puentes, 479 F.3d 1220, 1228–29 (10th Cir. 2007) (remanded for further proceedings to apply clear and convincing test for effectiveness of medication in light of defendant's specific low intelligence and deeply entrenched delusions).

126. United States v. Grape, 549 F.3d 591, 603–05 (3d Cir. 2008).

127. *See* United States v. Fazio, 599 F.3d 835, 840–41 (8th Cir. 2010) (finding the plan likely to restore competency when expert testified there was a 75–87% chance that recommended medications would restore competency); United States v. Evans, 427 F. Supp. 2d 696, 700–03 (W.D. Va. 2006) (giving weight to an expert opinion that Evans had 70–80% chance of being restored to competency); United States v. Gomes, 305 F. Supp. 2d 158, 165 (D. Conn. 2004) (stating that the Bureau of Prisons had at least a 70% success rate in restoring defendants with psychotic disorders similar to Gomes's disorder).

128. *See, e.g.,* United States v. Ghane, 392 F.3d 317, 319–20 (8th Cir. 2004) (holding that medication for delusional disorder, which was only effective in 10% of patients, was not substantially likely to render defendant competent); United States v. Rix, 574 F. Supp. 2d 726, 735–36 (S.D. Tex. 2008) (holding that a study, which found a competency restoration rate of 25%, was inadequate to satisfy the second *Sell* criterion).

129. Sell v. United States, 539 U.S. 166, 181 (2003).

130. NIMH, MENTAL HEALTH MEDICATIONS 3 (2012), *available at* http://www.nimh.nih.gov/health/publications/mental-health-medications/nimh-mental-health-medications.pdf.

131. *Id.* at 2–3.

132. *Id.* at 3.

133. Riggins v. Nevada, 504 U.S. 127, 142 (1992) (Kennedy, J., concurring).

134. *Id.* at 142–44.

cause a defendant to appear cold or unfeeling, which in a capital sentencing proceeding, may be determinative of whether he lives or dies.[135]

The effect of the medication on the defendant's trial rights must be considered before forced medication is authorized.[136] The government can show that a proposed treatment is unlikely to affect trial rights by establishing protocols prior to administering the medication.[137] In *United States v. Gallaway*, the Tenth Circuit found that trial rights would not be affected because medical experts outlined a plan to minimize potential side effects.[138] The experts testified that they would monitor Gallaway's condition and either modify or terminate treatment if they observed significant side effects.[139] Courts have also found trial rights to be unaffected by forced medication based on previous observations of a successfully medicated defendant.[140] In *United States v. Grape*, the defendant appealed a *Sell* order authorizing forced medication on the basis that the government did not meet its burden of proving the medication's side effects would not interfere with his trial rights.[141] While the order was stayed, Grape assaulted a corrections officer and was forcibly medicated on the *Harper* grounds of dangerousness.[142] After being medicated, he was found competent to stand trial, but he continued his appeal because the government planned to use the original *Sell* order if he again became incompetent.[143] The Third Circuit held that any side effects of the medication did not significantly interfere with Grape's right to a fair trial because he was found to be competent to stand trial while experiencing the effects.[144]

The dual requirement of the second prong of the *Sell* analysis requires courts to evaluate both the medical opinions regarding the effectiveness of a proposed medication and the legal implications of potential side effects on the defendant's trial rights. Courts are most likely to find a treatment effective when the government has shown statistical evidence of the drug's success or a previous successful treatment of the defendant with the proposed medication. If side effects are slight and protocols are in place to minimize those effects, courts are more likely to find the drug not to interfere with the defendant's trial rights. Because the defendant's Sixth Amendment rights are at stake in this analysis, this prong is possibly the most crucial of the four-part *Sell* standard. A drug that dulls cognition or causes sedation can make the defendant appear callous or unremorseful, which affects that defendant's right to a fair trial. The point at which side effects begin to

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135. *Id.* at 144.

136. United States v. Miller, 292 F. Supp. 2d 163, 164 (D. Me. 2003) (finding that adequate consideration was not given to the likely side effects on the defendant, which might undermine fairness of the trial).

137. *See* United States v. Gallaway, 422 Fed. App'x 676, 681 (10th Cir. 2011).

138. *Id.*

139. *Id.*

140. *See* United States v. Grape, 549 F.3d 591, 603–04 (3d Cir. 2008).

141. *Id.*

142. *Id.* at 592.

143. *Id.*

144. *See id.* at 593, 605.

infringe on the right to a fair trial is difficult to determine and requires a combination of expert medical and legal understanding.

3. Necessary and Medically Appropriate

The third and fourth prongs of the *Sell* analysis require the court to conclude that the treatment is necessary and that the proposed medication is medically appropriate before ordering a defendant to be involuntarily medicated.[145] A particular treatment is necessary if there are no less intrusive treatments that are likely to achieve the same result.[146] A treatment plan is medically appropriate if it is in the patient's best interests in light of his medical condition.[147] While non-drug treatments, such as psychotherapy, may be effective in restoring competency in some individuals, these techniques are thought to be less effective than antipsychotic drugs in treating schizophrenia and other disorders where delusional thinking is a symptom.[148]

In *United States v. Gomes*, for example, the court relied on testimony of doctors that verbal therapy would be ineffective primarily because one of the delusions the defendant had was that he was mentally sound.[149] If a paranoid defendant has delusions that the judge, prosecutor, and his attorney are part of a conspiracy against him, psychotherapy may be unlikely to help him understand the judicial proceedings, especially if he is inclined to believe his therapist is part of the conspiracy.[150] Even if a non-drug treatment, such as therapy, could restore a defendant to trial competency, this treatment may not be *medically appropriate* if antipsychotic drugs are better suited to treat the patient's medical needs. When a defendant's medical needs require a more intrusive treatment than the minimum treatment necessary to restore a defendant to trial competency, an inherent tension between these two requirements is revealed.

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145. Sell v. United States, 539 U.S. 166, 181 (2003).

146. *Id.*

147. *Id.*

148. *See* Motion for Leave to File Brief for Amicus Curiae American Psychological Ass'n & Brief for Amicus Curiae American Psychological Ass'n at 13, Sell v. United States, 539 U.S. 166 (2003) (No. 02-5664), 2002 WL 31898300, at *13 [hereinafter Brief for Amicus Curiae American Psychological Ass'n]; *see also* AM. PSYCHIATRIC ASS'N, PRACTICE GUIDELINES FOR THE TREATMENT OF PSYCHIATRIC DISORDERS: COMPENDIUM 573–76 (2006) (recommending pharmacological treatment be initiated promptly in diagnoses of schizophrenia with psychosocial treatments augmenting medication in stabilization and stable phases). *But see* Matt Irwin, *Treatment of Schizophrenia Without Neuroleptics: Psychosocial Interventions Versus Neuroleptic Treatment*, 6 ETHICAL HUM. PSYCHOL. & PSYCHIATRY 99 (2004) (reviewing six studies that suggest long-term outcomes for persons diagnosed with schizophrenia are better with psychosocial treatment programs that do not use antipsychotic drugs than with drug-based programs).

149. 387 F.3d 157, 162 (2d Cir. 2004).

150. Brief for Amicus Curiae American Psychological Ass'n, *supra* note 148, at 13.

C. Tension with Professional Judgment Standard

In *Harper*, the Supreme Court held that the State can forcibly medicate a prisoner if he is a danger to himself or others and the treatment is in his medical interest.[151] The Court concluded that the inmate's interests were "perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge."[152] The Court deferred to medical professionals because they have "the requisite knowledge and expertise to determine whether the drugs should be used in an individual case."[153] Deference to the judgment of medical practitioners with regard to mental health issues is known as the professional judgment standard.[154]

The Supreme Court's use of the professional judgment standard began to develop in *Parham v. J.R.*[155] In *Parham*, the Court held that non-consenting minors could be admitted to mental hospitals without a hearing before a judge.[156] The Court reasoned that medical decisions do not require a judicial or administrative officer to preside over the hearing because "neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments."[157] In *Youngberg v. Romeo*, the Court extended the standard to substantive rights.[158] Romeo was a severely mentally retarded man who was committed to a Pennsylvania State hospital.[159] After suffering numerous injuries because of his own violence and the reactions of other residents to him, Romeo was physically restrained during portions of each day.[160] The Court held that Romeo had a constitutionally protected right to safe conditions and was entitled to "minimally adequate training" that was "reasonable in light of [his] liberty interests in safety and freedom from unreasonable restraints."[161] In deciding what training was reasonable to keep Romeo safe while minimizing physical restraint, the Court deferred to a qualified professional's judgment.[162] The Court stated that professional medical decisions are entitled to a "presumption of correctness."[163]

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151. Washington v. Harper, 494 U.S. 210, 227 (1990).

152. *Id.* at 231.

153. *Id.* at 230 n.12.

154. *See* Youngberg v. Romeo, 457 U.S. 307, 323 (1982); Shaw *ex rel* Strain v. Strackhouse, 920 F.2d 1135, 1145 (3d Cir. 1990); Scothorn v. Kansas, 772 F. Supp. 556, 561–62 (D. Kan. 1991).

155. *See* 442 U.S. 584, 607 (1979).

156. *Id.*

157. *Id.* (quoting *In re* Roger S., 569 P.2d 1286, 1299 (1977) (Clark, J., dissenting)).

158. 457 U.S. at 322–23 (finding a substantive due process right to minimally adequate training and directing courts to defer to professional judgment to decide what training is reasonable).

159. *Id.* at 309.

160. *Id.* at 310.

161. *Id.* at 322.

162. *Id.*

163. *Id.* at 324.

In the context of forced medication for restoring competency, the court still looks to the expert opinion of medical practitioners to determine if the medication is medically appropriate, but does not necessarily defer to that judgment. Under *Sell*, the state must prove by clear and convincing evidence that the medication is in the patient's best interests in light of his specific medical condition.[164] The court must then find the treatment plan *both* medically appropriate *and* the least intrusive means to achieve competency. These requirements seem to be irreconcilable with the professional judgment standard applied in civil confinements because, in a *Sell* hearing, the court does not defer to the doctor's professional judgment. The medical appropriateness of a specific treatment does not change because the individual is awaiting trial. It does not hinge on whether the individual is competent. A treatment is medically appropriate if it is in a patient's best interests in light of his medical condition. This is essentially a medical question, yet the court has drifted away from the professional judgment standard in the context of a pretrial detainee who lacks trial competency.

II. PRACTICAL EFFECT OF TWO STANDARDS: THE DANGEROUSNESS LOOPHOLE

The Supreme Court suggested in *Sell* that the standard to forcibly medicate a defendant to render him competent for trial might rarely be met.[165] The court does not need to consider the test, however, if forced medication is permitted for another purpose. The Court noted that "[t]here are often strong reasons for a court to determine whether forced administration of drugs can be justified on these alternative grounds *before* turning to the trial competence question."[166] An analysis under the *Harper* standard is considered more "objective and manageable" than one under *Sell*.[167] If the government authorizes forced medication on the grounds of dangerousness, the need to medicate for competency will likely disappear.[168] The Court reasoned that a *Harper* analysis—even if unsuccessful—will inform the court in a *Sell* hearing by focusing the inquiry on the specific legal and medical issue.[169]

A. Finding of Dangerousness

Forcibly medicating a detainee under the *Harper* standard will likely be easier than under the heightened standard of *Sell*. A detention facility seeking to medicate a defendant under *Harper* can do so if he is dangerous to himself or others and the treatment is in his medical interests.[170] If the defendant objects, the government need only prove its decision is reasonably related to legitimate

164. Sell v. Unites States, 539 U.S. 166, 180–81 (2003).
165. *Id.* at 180.
166. *Id.* at 182.
167. *Id.* (quoting Riggins v. Nevada, 504 U.S. 127 (1992) (Kennedy, J., concurring)).
168. *See id.* at 183.
169. *See id.* at 182.
170. Washington v. Harper, 494 U.S. 210, 227 (1990).

penological interests.[171] A finding of dangerousness obviates the need for balancing the government's interest in bringing the accused to trial against the defendant's significant liberty interest in being free from unwanted medication. In *Harper*, the Supreme Court did not set a standard for what constitutes danger, but instead deferred to the judgment of the lower courts and examining psychiatrists.[172]

Courts have upheld findings of dangerousness based on acts of the defendant prior to incarceration,[173] the nature of the alleged crime,[174] and the nature of the illness itself, without reference to specific acts or tendencies.[175] Findings of dangerousness based on acts that occurred before the incarceration—including the alleged crime—do not serve the supposed purpose in *Harper* of protecting the safety of prison officials and inmates because there is not an immediate threat. Additionally, relying on the nature of the alleged crime to support a finding of dangerousness necessarily assumes the defendant committed the crime. Merely being accused of a dangerous crime does not make a person dangerous. The determination of guilt or innocence is the basis of the "important governmental interests" under the *Sell* analysis.[176] The other three prongs of the test serve to protect the defendant's right to a fair trial, which is also a "concomitant constitutionally essential interest" of the government.[177] Any finding of dangerousness based on the alleged crime bypasses the fundamental protections of the adversarial trial system.

A finding of dangerousness supported by the nature of the underlying illness without reference to specific acts or tendencies might extend to all persons

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171. *Id.* at 223–24.

172. *Id.* at 231–33.

173. *See* United States v. Weston, 134 F. Supp. 2d 115, 130 (D.C. Cir. 2001) (basing finding of dangerousness on individual's past violent behavior, underlying condition, and lack of regret for past violent behavior); United States v. Keeven, 115 F. Supp. 2d 1132, 1133–34 (E.D. Mo. 2000) (finding dangerousness in part because of defendant's past aggressive behavior); *see also Sell*, 539 U.S. at 174 (stating that the lower court found dangerousness based on Sell's infatuation with a nurse).

174. *See* United States v. Husar, 859 F.2d 1494, 1495–98 (D.C. Cir. 1988) (finding that the act of smashing the glass case that housed the original Constitution and Bill of Rights was sufficient to establish dangerousness); *see also* United States v. Arena, No. 00 CR. 398(JFK), 2001 WL 1335008, at *4 (S.D.N.Y. Oct. 30, 2001) (approving forced medication of incompetent defendant facing drug conspiracy charges because of essential government interest in punishing crime, but finding that "dealing in 450 kilograms of cocaine is 'dangerous' to the community").

175. *See* United States v. Muhammad, 165 F.3d 327, 336 (5th Cir. 1999) (finding defendant dangerous because her future physical or medical problems may not be detected or diagnosed); United States v. S.A., 129 F.3d 995, 1001 (8th Cir. 1997) (finding that the defendant's violent hallucinations and prior violent behavior are enough to support finding of dangerousness); United States v. Steil, 916 F.2d 485, 486–88 (8th Cir. 1990) (finding violent delusions and threats sufficient to prove dangerousness even though detainee never had opportunity to act on them).

176. *Sell*, 539 U.S. at 180.

177. *See id.* at 180–81.

suffering with schizophrenia. *United States v. Muhammad* involved a federal prisoner, convicted of bank robbery, who was transferred to a psychiatric hospital because she was found to be a danger to herself or others.[178] Muhammad refused to cooperate in a psychiatric evaluation, remained isolated in her cell due to fear of religious persecution, and did not interact with staff or inmates of the facility.[179] Medical personnel concluded that her deterioration in functioning and isolation were the result of a "severe psychotic process in which she suffers from persecutory and religious delusions" and diagnosed her with paranoid schizophrenia.[180] A magistrate judge found her to be a danger to herself because her refusal to accept treatment meant that any future physical or medical problems would go undetected or undiagnosed.[181] It is difficult to imagine how *any* refusal of treatment would not cause future medical problems to go undetected or undiagnosed. Most individuals suffering with schizophrenia do not realize their symptoms are a result of the illness.[182] Without treatment, these symptoms could worsen, causing undetected medical problems. By the logic of *Muhammad*, any schizophrenic who refuses treatment could be considered a danger to himself and therefore subject to forced medication.

The Supreme Court's direction for lower courts to first conduct a *Harper* analysis before considering a *Sell* hearing has paved the way for prosecutors to circumvent the heightened scrutiny of *Sell* in favor of a reasonably related standard simply by showing the defendant is a danger to himself or others. Several commentators have noticed this apparent loophole and have suggested a single standard to close the loophole and protect the right of the incompetent criminal defendant to refuse medication.[183] Others have proposed changes in criminal procedure to mitigate the impact that forced medication has on a defendant's Sixth Amendment rights.[184]

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178. 165 F.3d at 328.

179. *Id.* at 335. Muhammad was Muslim and believed the other inmates would kill her because of her faith. *Id.*

180. *Id.*

181. *Id.* at 336.

182. DSM-TR-IV, *supra* note 20, § 295 ("A majority of individuals with schizophrenia have poor insight regarding the fact that they have a psychotic illness.").

183. *See* Kristin L. Henrichs, Note, *Forcible Antipsychotic Medication: Should the Mentally Ill Criminal Defendant Celebrate or Fear* Sell v. United States, 90 IOWA L. REV. 733, 764 (2005) (suggesting the *Sell* analysis be applied to all forcible medication decisions); Emily C. Lieberman, Note, *Forced Medication and the Need to Protect the Rights of the Mentally Ill Criminal Defendant*, 5 CARDOZO PUB. L. POL'Y & ETHICS J. 479, 498 (2007) (calling for rejection or clearer definition of dangerousness and strict scrutiny review for all forced medication decisions); Gregg Single, Note, United States v. Sell*: Involuntary Administration of Antipsychotic Medication. Are You Dangerous or Not?*, 18 J.L. & HEALTH 297, 316–21 (2003–2004) (calling for strict scrutiny standard in all forcible medication cases).

184. *See* Brenda A. Likavec, Note, *Unforeseen Side Effects: The Impact of Forcibly Medicating Criminal Defendants on Sixth Amendment Rights*, 41 VAL. U. L. REV. 455, 491–92 (2006) (proposing a rebuttable presumption of "not guilty by reason of mental disease or defect" in cases where the defendant has been forcibly medicated).

B. Equal Protection Issue

Another troubling aspect of the two standards for forced medication is the potential violation of the constitutional guarantee of "equal protection of the laws."[185] The Equal Protection Clause allows the government to treat similarly situated individuals differently with regard to fundamental interests only if the classification is "precisely tailored to serve a compelling governmental interest."[186] A defendant who is not competent for trial and is not considered dangerous can be forcibly medicated only after an inquiry into the possible effects of the medication on his right to a fair trial, while a dangerous defendant can be medicated without this protection. Both individuals have the same constitutionally protected interest in receiving a fair trial. If a proposed medication will cause the non-dangerous defendant to become excessively drowsy or unable to pay attention to prosecution witnesses, the *Sell* analysis will likely protect him from the forced medication, but a dangerous defendant could be forcibly medicated under the same circumstances without the protection of a *Sell* hearing.[187]

It is unclear whether a defendant medicated for dangerousness and then found competent for trial will be protected against possible prejudicial side effects of the medication. The competency evaluation focuses on the defendant's ability to understand and assist in his defense, but it may not protect against the concerns, noted by Justice Kennedy in *Riggins*, that the jury's perception of the defendant could be altered by side effects of the medication.[188] The Court suggested in *Sell* that forced medication on dangerousness grounds should be sought prior to seeking an order to medicate under the more restrictive competency for trial grounds.[189] But the Court did not provide a sufficient justification for the different treatment of dangerous and non-dangerous defendants.[190] To protect every defendant's fair trial rights, competency evaluations of all forcibly medicated detainees should include an inquiry into the effect of the drug on the defendant's demeanor.

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185. U.S. CONST. amend. XIV, § 1; *see* Dora W. Klein, *Curiouser and Curiouser: Involuntary Medications and Incompetent Criminal Defendants after* Sell v. United States, 13 WM. & MARY BILL RTS. J. 897, 915 (2005) (suggesting the instruction in *Sell* to first determine if forced medication can be made on dangerousness grounds is an "invitation to violations of the constitutional guarantee of 'equal protection of the laws'").

186. Plyler v. Doe, 457 U.S. 202, 217 (1982).

187. *See* Klein, *supra* note 185, at 916–17.

188. 504 U.S. 127, 142–44 (1991) (Kennedy, J., concurring).

189. Sell v. United States, 539 U.S. 166, 167–68 (2003).

190. Klein, *supra* note 185, at 917–19. Klein notes that the only government interest identified in *Sell* as a possible justification for "unequal protection of incompetent defendants' trial rights is that the criteria for" forced medication of dangerous persons is "more 'objective and manageable' than the criteria for" forced medication solely to render a defendant competent for trial. *Id.* at 918.

III. REEVALUATION OF GOVERNMENT AND LIBERTY INTERESTS AND CONSIDERATION OF OUTCOMES

The problems with the *Sell* and *Harper* standards cannot be resolved with a move to a single strict scrutiny standard. While a single strict scrutiny standard would close the dangerousness loophole and ensure that fair trial rights would be protected for all forcibly medicated defendants, it would also create greater incentives for defendants to refuse medication to avoid prosecution. Governments would have a harder time medicating defendants who refused. It would result in more suffering from untreated mental illness and, ironically, a greater loss of autonomy for those individuals. To resolve these problems, this Note reevaluates individual liberty interests and government interests with a focus on likely outcomes from each decision.

Reevaluating the individual's liberty interest is necessary to properly analyze the balance between the government interest in bringing an accused defendant to trial and that defendant's liberty interest in being free from unwanted antipsychotic medication. A defendant's right to refuse medication and instead suffer with a mental illness that itself robs the individual of his autonomy and liberty of thought begs the question—what autonomy is being protecting? A thorough analysis also must examine the potential outcomes of both forcibly medicating the defendant to competency and preserving his right to refuse treatment. The goals of jurisprudence that make adjudication of a serious crime an important governmental interest will shift during the process and may not be better served by rendering the defendant competent for trial.

A. What Autonomy Is Protected?

An individual's right to control his own person is deeply rooted in American history and common law.[191] This right is implicit in the doctrine of informed consent, which extends to the right to refuse unwanted medication.[192] The central element of the right to refuse treatment is that the choice of the individual over matters affecting his own body must be protected. The individual's autonomy in matters of bodily integrity is important enough to permit a competent person to make unwise medical decisions and even refuse lifesaving treatments.[193] But what autonomy is protected by allowing an individual to refuse treatment for an illness that warps his understanding of reality and his relation to the world? The Supreme Court has stated "choices central to personal dignity and autonomy[] are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the

191. *See* Union Pac. Ry. v. Botsford, 141 U.S. 250, 251 (1891) ("No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others . . . .").

192. *See* Cruzan *ex rel* Cruzan v. Dir., Mo. Dept. of Health, 497 U.S. 261, 278 (1990).

193. *See* Thor v. Superior Court, 855 P.2d 375, 381 (Cal. 1993).

universe, and of the mystery of human life."[194] A person suffering with untreated schizophrenia does not choose his concept of existence or meaning, but instead has his reality twisted and torn apart by the disease.

Schizophrenia is characterized by profound disruptions in cognition and emotion.[195] The disease causes hallucinations, delusions, and disorientation that can shatter an individual's language, perception, and sense of self.[196] In addition to the fear and helplessness caused by schizophrenia, most individuals afflicted with the disease do not believe they have a disorder.[197] This lack of insight into the nature of the hallucinations and distortions of reality is a prevalent feature of the disease and is one of the best predictors of whether a person will refuse treatment.[198] Studies have found a correlation between increased delusionality, thought-disorder, and disorganized behavior, and decreased awareness that the patient has a mental illness.[199] The more a person suffers from the disease, the less likely he is to understand it is a disease and to seek—or accept—treatment. By affecting the perception of reality and self, the disease directly impacts any treatment decision made by the afflicted person.

If autonomy is to be protected as a central aspect of liberty, courts should authorize treatment of schizophrenia in many cases when the patient refuses. The disease robs the individual of his ability to make meaningful choices by distorting reality and convincing him that he is not ill.[200] Untreated schizophrenia represents a much greater and persistent threat to the autonomy of the individual than preventing the choice of a mentally ill person to refuse treatment. If the goal is to

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194. Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 851 (1992).

195. DSM-IV-TR, *supra* note 20, § 295.

196. *See, e.g.*, ELYN R. SAKS, THE CENTER CANNOT HOLD: MY JOURNEY THROUGH MADNESS 13 (2008). Saks describes an early experience of "disorganization" as follows:

> Consciousness gradually loses its coherence. One's center gives way. The center cannot hold. The "me" becomes a haze, and the solid center from which one experiences reality breaks up like a bad radio signal. There is no longer a sturdy vantage point from which to look out, take things in, assess what's happening.

Id.

197. DSM-IV-TR, *supra* note 20, § 295 ("A majority of individuals with schizophrenia have poor insight regarding the fact that they have a psychotic illness."); Peter F. Buckley et al., *Lack of Insight in Schizophrenia: Impact on Treatment Adherence*, 21 CNS DRUGS 129, 129–30 (2007).

198. XAVIER F. AMADOR & HENRY KRONENGOLD, *Understanding and Assessing Insight*, *in* INSIGHT AND PSYCHOSIS: AWARENESS OF ILLNESS IN SCHIZOPHRENIA AND RELATED DISORDERS 3, 4, 26 (Xavier F. Amador & Anthony S. David eds., 2d ed. 2004).

199. *See id.* at 14.

200. *See* AMADOR & KRONENGOLD, *supra* note 198, at 4 ("[D]eficits in insight most often stem from the disorder itself, from brain dysfunction, rather than from defensive coping strategies."); Thomas G. Gutheil, *In Search of True Freedom: Drug Refusal, Involuntary Medication, and "Rotting with Your Rights On,"* 137 AM. J. PSYCHIATRY 327, 327 (1980) ("[P]sychosis is itself involuntary mind control of the most extensive kind and itself represents the most severe 'intrusion on the integrity of a human being.'").

maximize autonomy, steps should be taken to treat the disease and alleviate symptoms. John Stuart Mill's essay, *On Liberty*,[201] a highly influential defense of individual freedom, was published less than a decade before the Fourteenth Amendment was passed. Mill considered governmental restraint of individual choice to be improper,[202] but he acknowledged the right of the government to infringe individual liberty to protect others.[203] For Mill, individual autonomy is also justifiably limited when an individual choice would otherwise eliminate future autonomy. He wrote that autonomy should not be protected to the extent of allowing an individual to sell himself into slavery because:

> [B]y selling himself for a slave, he abdicates his liberty; he foregoes any future use of it, beyond that single act. He therefore defeats, in his own case, the very purpose which is the justification of allowing him to dispose of himself. He is no longer free; but is thenceforth in a position which has no longer the presumption in its favor, that would be afforded by his voluntarily remaining in it. The principle of freedom cannot require that he should be free not to be free. It is not freedom, to be allowed to alienate his freedom.[204]

The test for competency to refuse medication is whether the individual is a danger to himself or others and whether he is able to make rational and informed treatment decisions. Government actions that infringe on individual autonomy are justified when they prevent harm caused by both competent and incompetent persons. If a mentally ill person is found to be not dangerous to himself or others, and able to make rational treatment decisions, he is legally competent to refuse medication. In these situations, however, the individual's autonomy should not be supported to the extent that he abdicates that liberty.

A schizophrenic but legally competent person who refuses treatment potentially surrenders his decision-making ability when the disease erodes his ability to relate to the world around him. However, during a lucid interval, a person with schizophrenia could be legally competent to refuse treatment. But this decision should not be protected as part of his autonomy. By refusing treatment and allowing the disease to progress, the individual abdicates his liberty. As Mills wrote, "[t]he principle of freedom cannot require that he should be free not to be free."[205]

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201. JOHN STUART MILL, ON LIBERTY (P.F. Collier & Son 1909) (1860), *available at* http://www.constitution.org/jsm/liberty.htm.

202. Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1705, 1712 (1992).

203. MILL, *supra* note 201. Mill's "harm principle" states that "the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. . . . [T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others." *Id.*

204. *Id.*

205. *Id.*

The liberty interest in allowing an individual to make choices about his person cannot be evaluated without looking at what choices are made. The decision to refuse medication is a choice to suffer with terrible, though treatable, symptoms of a disease the individual most likely does not realize he has.

For some patients, antipsychotic drugs cause side effects that create a substantial interference with liberty. Approximately 90% of antipsychotics prescribed for schizophrenia are second-generation, atypical drugs.[206] Although second-generation antipsychotic medications are effective in reducing symptoms of schizophrenia, some patients discontinue their use because of side effects. The Clinical Antipsychotic Trials of Intervention Effectiveness ("CATIE") study initiated by the National Institute of Mental Health in 2005 evaluated the effectiveness of all available second-generation antipsychotics and found that 10–18% of participants discontinued treatment due to side effects.[207] Between 2–9% discontinued use because of weight gain or metabolic effects, and 2–8% stopped use because of extrapyramidal effects, such as tremors.[208] The mean weight change over the 18-month study was between –2.0 lbs and +9.4 lbs.[209]

The majority of participants in the CATIE study discontinued use sometime during the 18-month trial, which illustrates the limitations of antipsychotic medications. Between 24–34% of patients stopped taking the medication because of an independent decision not directly related to side effects.[210] Side effects of antipsychotics can be serious. In some instances, the goals of promoting autonomy and reducing suffering may be outweighed by the intrusion of serious side effects on the individual.

Assuming that an individual's choice to refuse treatment should be protected as a liberty interest, it is not clear why protecting this autonomy should be valued above other interests like diminishing psychosis or reducing suffering.

B. Other Government Interests

The right to refuse medical treatment is not absolute. Government interests in (1) preserving life, (2) protecting innocent third parties, (3) preventing suicide, and (4) maintaining the ethical integrity of the medical profession can outweigh a competent individual's right to refuse treatment.[211] Courts have upheld involuntary medical treatments involving blood transfusions for children despite

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206. Jeffrey A. Lieberman et al., *Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia*, 353 NEW ENG. J. MED. 1209, 1210 (2005). Second generation, or atypical, antipsychotic drugs differ pharmacologically and were developed to reduce the incidence of extrapyramidal symptoms and tardive dyskinesia. *Id.*

207. *See id.* at 1213, 1220 tbl.3.

208. *See id.*

209. *See id.*

210. *See id.* at 1217 tbl.2.

211. *See* Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 425 (Mass. 1977).

the opposition of the parents,[212] cesarean sections to preserve the life of viable fetuses,[213] and treatment when the patient had dependent minor children.[214] The state interests in prolonging life are strongest when the affliction is curable and the patient's life may be extended for a long period of time.[215] These interests may be implicated in many cases involving mentally ill patients. The state interest in maintaining the integrity of the medical profession may be equally strong in such cases.

The state has an interest in the ethical integrity of the medical profession, as well as in allowing hospitals the full opportunity to care for people under their control. While prevailing medical ethics recognize that a dying patient is often more in need of comfort than prolonged life, a mentally ill person is typically most in need of treatment. Medical professionals have the ability to alleviate the suffering caused by illnesses such as schizophrenia but are unable to care for those who refuse the treatment. Instead, they must stand by while those in their care suffer needlessly. The government also has an interest in not being cruel to those who, because of poor insight, suffer with a treatable disease.

A decision to allow a mentally ill person to refuse treatment implies that the court values the individual's autonomy and bodily integrity more than reducing that individual's suffering. But why is this "autonomy" valued above the suffering? A disease that distorts perceptions of reality and causes delusional thoughts clearly diminishes the individual's ability to make a meaningful choice, yet that choice is implicitly valued above the very real harm caused to the person. As the delusions and hallucinations become stronger, the person is more likely to believe he does not have a disease and to refuse treatment. Thus, protecting his autonomy to refuse treatment is implicated most often in cases where the individual is suffering the most.

C. Possible Outcomes of Medicating to Competency

The government interest in bringing a criminal defendant accused of a serious crime to trial has sometimes been considered important enough to outweigh an individual's liberty interest in not being medicated.[216] But just as the freedom of choice must be understood in the context of what the choice is, the government's interest in forcibly medicating an incompetent defendant must be understood in the context of possible outcomes of rendering him competent. The Supreme Court has held that case-by-case determinations must be made to properly evaluate the government interest and that special circumstances—such as

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212. *See, e.g.*, Morrison v. State, 252 S.W.2d 97, 103 (Mo. Ct. App. 1952); State v. Perricone, 181 A.2d 751, 753 (N.J. 1962); Tennessee, Dep't of Human Servs. v. Hamilton, 657 S.W.2d 425, 429 (Tenn. Ct. App. 1983).

213. *See* Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., 66 F. Supp. 2d 1247, 1251–52 (N.D. Fla. 1999); Jefferson v. Griffin Spalding Cnty. Hosp. Auth., 274 S.E.2d 457, 458–60 (Ga. 1981).

214. *See In re* Dubreuil, 629 So. 2d 819, 820 (Fla. 1993).

215. *Saikewicz*, 370 N.E.2d at 425–26.

216. *See* Sell v. United States, 539 U.S. 166, 179 (2003).

the likelihood of future civil commitment or a previous lengthy period of detention—can mitigate that interest.[217] Cases that require the *Sell* analysis involve criminal defendants who are incompetent for trial but who are not dangerous enough to themselves or others while in confinement to permit forcible medication under *Harper* grounds. This does not mean that they do not pose a threat to themselves or others if they were to be released.[218] Currently, courts look at possible future harm in making a determination of danger, but other likely outcomes should be examined as part of the decision to forcibly medicate.

In federal courts, a criminal defendant who is medicated to competency and tried will be found guilty, not guilty, or not guilty by reason of insanity.[219] A not guilty verdict is the best outcome for the defendant because he will not be confined, he will have received at least enough treatment to regain competency, and he is more likely to continue treatment. A not guilty by reason of insanity verdict will typically result in a civil confinement.[220] A guilty defendant will face confinement whether he is forcibly medicated or not because even without medication and a guilty verdict, he will continue to be confined civilly. In prison, he will receive the medication and treatment for his disease, but a criminal defendant will only be detained civilly if he refuses treatment while awaiting trial. The goal of incapacitation is met in both outcomes, but the goals of retribution and rehabilitation strongly favor medication.

Perhaps the greatest ethical concerns with forced medication arise when the defendant is accused of a capital crime and a death sentence is a possible outcome. Two significant issues arise in capital cases involving incompetent defendants. First, forcibly medicating a defendant to seek the death penalty does not appear to be in his best medical interests. Second, because the government interest is satisfied once the defendant is tried, there is probably not a strong enough state interest to continue forced medication in order to actually execute the convicted criminal.

Forcing a defendant to take medication in order to seek the death penalty is arguably not in his best medical interests. The government interest in bringing

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217. *Id.* at 180.

218. *See, e.g.*, United States v. Moruzin, 583 F. Supp. 2d 535, 546 (D.N.J. 2008) (finding that while Moruzin was not presently a danger to himself or others while in a secure mental health unit, "this is a far cry from suggesting that he *would not* 'create a substantial risk of bodily injury to another person or serious damage to property of another' if released"). The New Jersey District Court found that Moruzin's conduct over the course of the proceedings and his unwillingness to take antipsychotic medication, showed "every indication" that he would be a risk if released. *Id.*

219. *See* 18 U.S.C. § 4242 (2012). Insanity is an affirmative defense which requires a psychological examination to determine if the defendant was insane at the time of the offense. *Id.* at § 4247(c)(4). Some states have created "guilty but mentally ill" verdicts which allow a finding of guilty but acknowledge the mental illness and need for treatment. *See, e.g.*, ALASKA STAT. § 12.47.030 (2012); DEL. CODE ANN. tit. 11, § 401(b) (2012); GA. CODE ANN. § 17-7-131 (2012); 730 ILL. COMP. STAT. ANN. 5/5-2-6 (2012); *see also* ARIZ. REV. STAT. § 13-502 (2012) (guilty except insane verdict).

220. *See* 18 U.S.C. § 4243.

the defendant to trial is at its highest in cases involving "serious" crimes, such as murder, but to forcibly medicate a defendant in order to make him competent the government must also prove that the medication is in his best medical interest. The government is in the strange position of first arguing that the forced medication is the best way to protect the defendant's health and then asking a jury to sentence him to death. The court also must rely on medical professionals to determine the best medical interests of the patient, but a doctor, whose oath is to "first do no harm," may not be able to ethically recommend a treatment if he knows it can lead to the patient's death.

The second issue is that the important government interest necessary to overcome the individual's liberty is the interest in bringing the accused to trial. Once the defendant is tried, this interest has been satisfied and the justification to forcibly medicate the defendant may no longer exist. The individual would be free to refuse medication once again and would most likely return to a state of incompetence, and possibly to a state of insanity. The Eighth Amendment protects an insane inmate from being executed,[221] but even before the Eighth Amendment was ratified common law prohibited executing the insane.[222] It is doubtful that the government could show a strong enough interest in carrying out the execution to outweigh the individual's liberty to refuse treatment. The supreme courts of Louisiana and South Carolina have both held that medicating a death-row inmate to competency for the purpose of execution is a violation of Due Process.[223] The U.S. Supreme Court has held that executions of mentally retarded[224] and juvenile offenders[225] are violations of the Eighth Amendment. It has been argued that an extension of these prohibitions to cover mentally ill defendants is necessary.[226] If the individual is convicted and sentenced to death but then refuses medication and

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221. *See* Panetti v. Quarterman, 551 U.S. 930, 934–35 (2007); Ford v. Wainwright, 477 U.S. 399, 409–10 (1986).

222. *Ford*, 477 U.S. at 407–10.

223. *See* Singleton v. State, 437 S.E.2d 53, 60–62 (S.C. 1993) (holding that medicating an insane inmate in order to execute him is a violation of state constitution and federal due process); State v. Perry, 610 So. 2d 746, 758 (La. 1992) ("When antipsychotic drugs are forcibly administered to further the state's interest in carrying out capital punishment, and therefore *not* done in the prisoner's best medical interest, the intrusion represents an *extremely severe* interference with that person's liberty.").

224. Atkins v. Virginia, 536 U.S. 304, 321 (2002).

225. Roper v. Simmons, 543 U.S. 551, 572–79 (2005) (prohibiting the execution of offenders who were under 18 years old when they committed their crime).

226. *See* John H. Blume & Sheri Lynn Johnson, *Killing the Non-Willing:* Atkins, *the Volitionally Incapacitated, and the Death Penalty*, 55 S.C. L. REV. 93, 95 (2003) ("[E]xecuting a defendant for conduct he was unable to control is a violation of the Eighth Amendment."); Christopher Slobogin, *What* Atkins *Could Mean for People with Mental Illness*, 33 N.M. L. REV. 293, 313–14 (2003) (arguing that because mentally ill murderers are no more culpable or likely to be deterred by capital punishment than juvenile or mentally retarded murderers, Equal Protection should prevent their execution); *see also* Lyn Entzeroth, *The Challenge and Dilemma of Charting a Course to Constitutionally Protect the Severely Mentally Ill Capital Defendant from the Death Penalty*, 44 AKRON L. REV. 529 (2011) (considering possible constitutional challenges in the development of an Eighth Amendment death penalty exemption for the mentally ill).

reverts to insanity, he is in a similar position as an incompetent defendant who is not forcibly medicated—confined indefinitely, suffering with the effects of his mental illness.

If death is a possible outcome of forced medication, the defendant's interest in refusing medication is also at its highest—because as long as he remains incompetent, he cannot be sentenced to death.[227] This creates perverse incentives for the defendant to refuse medication and continue to suffer with the terrible effects of an untreated mental illness because it is the best strategy to preserve his life.

Because of the hellish visions and paranoid delusions that accompany untreated schizophrenia, it may be better for a defendant to be medicated and face a possible death sentence than to continue to suffer with the disease. Schizophrenia can cause such a severe break with reality and such suffering that as many as half of those afflicted seek to end the pain by attempting suicide.[228] The effects of schizophrenia are so severe that the disease has been described in *Nature* as "arguably the worst disease affecting mankind, even AIDS not excepted."[229] While confinement in prison awaiting an eventual execution is certainly not a desirable position, fewer than 15% of those sentenced to death in the past 35 years have actually been executed.[230] Over a third have had their sentences or convictions overturned.[231]

The possible outcomes for a defendant forcibly medicated to competency range from a finding of innocence to a sentence of death. A guilty verdict or plea will most often result in the defendant being confined and continuing to receive needed medical treatment. A verdict of "not guilty by reason of insanity" will also likely result in civil confinement.[232] In each of these cases, the defendant is relieved of the suffering that accompanies untreated psychosis. The alternative is to refuse medication and be civilly confined for an indefinite period, suffering with the symptoms of mental illness. To prevent this alternative from being a strategically optimal position, an exception to the death penalty for severely mentally ill defendants is needed.

CONCLUSION

Forcible medication of incompetent persons involves complex legal and ethical issues. A person suffering with mental illness still has a constitutionally protected interest in liberty and autonomy of person. The Supreme Court in *Sell* affirmed a significant liberty interest in being free from unwanted medication and created a four-part test to ensure that both the liberty interest and the defendant's right to a fair trial would be protected.[233] However, the direction to first seek to

227. *See supra* notes 223–25.
228. *See supra* note 21.
229. *Where Next with Psychiatric Illness?*, NATURE, Nov. 10, 1988, at 95.
230. *See* SNELL, *supra* note 22, at 21.
231. *Id.*
232. *See, e.g.*, 18 U.S.C. § 4243 (2012); ARIZ. REV. STAT. § 13-502 (2012).
233. Sell v. United States, 539 U.S. 166, 180–81 (2003).

medicate on the basis of danger allows the state to avoid these protections and only requires a reasonableness standard of review. This loophole should be closed, but a move to a single strict scrutiny standard is not the answer. It will not resolve the incentive problem, promote true autonomy, or alleviate unnecessary suffering. Instead, what is needed is broader evaluation of government and individual interests and an exception to the death penalty for severely mentally ill defendants. The balance of interests should examine the true nature of the liberty interest in refusing medication when the individual suffers from an autonomy-robbing disease such as schizophrenia. It should also include the government interests in alleviating suffering, respecting life, and preserving the integrity of the medical profession.

When an illness such as schizophrenia distorts an individual's perception of reality and self through delusions and hallucinations, we must ask whether preserving the freedom to refuse medication promotes or impedes that person's autonomy. The liberty interest in refusing medication is greatly reduced in an individual who is afflicted with a mental illness that robs him of his ability to make a meaningful choice. The government interest in promoting autonomy actually favors medicating the individual in order to preserve future autonomy. Courts should not promote a defendant's decision to alienate his freedom.

Although the likelihood of a mentally ill defendant actually being executed is low,[234] an exception for severely mentally ill persons is needed to remove a strategic incentive to refuse treatment. As long as death is a possible outcome of going to trial, a person incompetent to stand trial has an incentive to refuse medication and avoid trial. A death penalty exception for severely mentally ill persons would remove this incentive and reduce unnecessary suffering. When execution is not a possible outcome, the balance of interests—of both the government and the individual—shifts toward promoting autonomy and relieving suffering through treatment and medication. If autonomy is to be protected as a fundamental liberty, the government should not protect a single decision to allow a treatable illness to erode an individual's future autonomy.

The current law purports to protect the significant liberty interest of a non-dangerous, mentally ill defendant to refuse medication, but in practice it creates powerful incentives for governments to make dubious findings of dangerousness and for mentally ill defendants to refuse medication and continue to suffer to avoid the possibility of death. In the narrow region of competency to refuse medication and incompetency to stand trial, individual liberty is imperiled by the likely advancement of the disease. An individual's autonomy interest in the decision to refuse treatment is not sufficient to outweigh the government's interests in promoting future autonomy and reducing suffering. When a court finds a defendant incompetent for trial, treatment decisions—including forced medication—should be made by the treating physicians with the best medical interests of the patient in mind.

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234. *See* SNELL, *supra* note 22, at 21.

In the pretrial context, the right most in need of protection is the defendant's right to a fair trial. Potential and actual side effects should be evaluated in all cases of forced medication of criminal defendants as part of every competency evaluation. This would close the dangerousness loophole and ensure fair trial rights are protected in all cases of forced medication. Though the *Sell* decision sought to protect autonomy and fair trial rights, it has created a landscape where mentally ill defendants seek to abandon future autonomy by refusing needed treatment and where governments seek to medicate on the basis of dangerousness, without the fair trial rights protection that *Sell* promised.