

ARTICLES

OLD LAW MEETS NEW MEDICINE: REVISITING INVOLUNTARY PSYCHOTROPIC MEDICATION OF THE CRIMINAL DEFENDANT*

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INTRODUCTION

Russell Eugene Weston, Jr. has two very serious problems. He has a major mental illness, paranoid schizophrenia, which causes him to lose touch with reality.¹ He has also been charged with two counts of murder of a federal officer while in performance of his duties, a potentially capital crime.²

At 3:40 p.m. on July 24, 1998, Weston tried to bypass a metal detector at the document room door of the U.S. Capitol Building,³ where he was confronted by Capitol Police Officer Jacob Chestnut. Weston fatally shot Officer Chestnut while tourists and bystanders ran

1. United States v. Weston, 206 F.3d 9, 19-20 (D.C. Cir. 2000) (Tatel, J., concurring) (describing Weston's history of mental illness and persistent delusional beliefs about a "Ruby Satellite System," controlled from the U.S. Capitol building, which through overuse has resulted in spread of "Black Heva," which will soon spread the "most deadliest disease known to mankind" and kill thirty-five percent of the U.S. population).

2. United States v. Weston, 36 F. Supp. 2d 7, 8 (D.D.C. 1999).

3. Martin Weil, *Gunman Shoots His Way Into Capitol*, WASH. POST, July 25, 1998, at A1.

screaming through the hall.⁴ Weston lunged through a door and into the outer office of the House Majority Whip.⁵ Already injured by another officer, Weston opened the door to the office and was confronted by Special Agent John Gibson. Both men fired.⁶ Weston fatally wounded Gibson, who himself wounded Weston.⁷ Officers then surged around Weston and shot him once more, while House employees hid beneath their desks.⁸

In videotaped interviews with psychiatrists, conducted at the jail, Weston explained that he did all this, after driving 750 miles from Illinois, to protect the American people from “the most deadliest disease known to mankind,” which he said was spread by the rotting corpses of the victims of cannibalism.⁹ He detailed how he had been trying to reach the “ruby satellite,” kept in a safe in the Senate, which could stop the cannibalism.¹⁰ Both men he had shot, he noted, were cannibals—part of a large conspiracy that included the court and much of the government.¹¹ He did not believe that his lawyers, who had been representing him for “millions of years,” were part of the conspiracy.¹²

This was not the first time Weston confronted government officials.¹³ In July 1996 he had gone to the Central Intelligence Agency and explained that President Clinton was “a Russian clone, brought to the United States for the purposes of communist insurgency.”¹⁴ Weston had been determined not to be a threat at that time, although in October of that year he was involuntarily committed to a mental hospital in Montana after he complained that he had been brainwashed.¹⁵

No trial of Weston’s case has yet occurred. The government initially argued that Weston could adequately control his delusions in order to stand trial. The government’s own chief correctional psychiatrist, Dr. Sally Johnson, found that Weston lacked the competence to stand trial,¹⁶

4. *Id.*

5. *Id.*

6. *Id.*

7. *Id.*

8. *Id.*

9. Bill Miller, *Weston’s Mind-Set Detailed: Capitol Suspect Feared Disease, Cannibal Threat*, WASH. POST, Apr. 23, 1999, at A1.

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.*

15. *Id.*

16. *Weston*, 36 F. Supp. 2d at 9 (stating that the standard for determining a defendant’s competence to stand trial is made pursuant to 18 U.S.C. § 4241(a), applying the standard of *Dusky v. United States*, 362 U.S. 402 (1960) (per curiam), under which the defendant must have sufficient present ability to consult with counsel with a reasonable degree of rational understanding, and a rational as well as a factual understanding of the proceedings against him).

but concluded that there was a seventy to seventy-five percent likelihood of his becoming competent through the administration of antipsychotic drugs.¹⁷

When Weston refused to take these medications voluntarily, a staff psychiatrist at the federal prison hospital where he was being held initiated a hearing¹⁸ to determine whether Weston should be involuntarily medicated.¹⁹ Weston had no access to counsel at the hearing, and was represented only by a hospital staff member. Upon the prior advice of the lawyers who were representing him in the criminal proceeding, Weston refused to make any statements in the hearing and refused to speak with the staff member who “represented” him.²⁰ No witnesses were interviewed or presented on Weston’s behalf, no evidence was adduced in support of his position, and no effort was made to notify his lawyers of the hearing.²¹ Based only on the testimony of the government psychiatrist who had evaluated Weston (the same one who had previously found him not competent, and now sought to have him medicated) the hearing examiner determined that Weston suffered from a mental disorder and that he needed medication.²² No determination was ever made that Weston was dangerous, and Weston’s subsequent appeal to the warden was unsuccessful.²³

After the results of this hearing were set aside by the trial court, which found that it had been conducted without notice to counsel (in violation of a prior order) and without the opportunity for Weston to present any favorable evidence, the prison hospital conducted a second hearing.²⁴ This time, counsel was notified of the hearing, and Weston’s representative (the same day-watch nursing supervisor who had previously served as his staff representative) presented a report by Weston’s expert, a psychiatrist, which found that medication was not likely to render him competent, that his delusions were too ingrained to respond to medication, and that the medication posed more significant

17. *United States v. Weston*, 55 F. Supp. 2d 23, 26 (D.D.C. 1999).

18. The hearing was held pursuant to 28 C.F.R. § 549.43, a Bureau of Prisons regulation which provides for an administrative hearing before a staff psychiatrist not currently involved with the inmate’s treatment or diagnosis to determine whether “treatment . . . is necessary in order to attempt to make the inmate competent for trial or is necessary because the inmate is dangerous to self or others, is gravely disabled, or is unable to function in the open population of a mental health referral center or regular prison.” 28 C.F.R. § 549.43(5). The inmate may appeal an adverse administrative decision to the institution’s mental health division administrator. *Id.*

19. *Weston*, 55 F. Supp. 2d at 26.

20. *Id.* at 25-26.

21. *Id.*

22. *Id.* at 26-27.

23. *Id.* at 25.

24. *Id.* at 26-27.

side effects than the government's expert had suggested.²⁵ Again, the psychiatrist from the prison hospital who conducted the hearing concluded that medication was medically appropriate and that, without medication, Weston was dangerous to himself and others.²⁶ More importantly, the psychiatrist concluded that he would *not become* competent with any less intrusive interventions.²⁷

Upon review by the district court, the results of this second hearing were upheld, based solely on the finding that Weston required medication so that he would not be dangerous.²⁸ The Court so found notwithstanding the fact that the only evidence concerning Weston's dangerousness while at a secure prison hospital was that hospital procedures were "adequate to prevent risk—to prevent episodes of harm to himself or to others."²⁹ Although his counsel raised the issue, the district court refused to consider whether medication was necessary to restore Weston's competence to stand trial and whether such restoration through medication posed a risk to his trial-related rights.³⁰ Medication might treat some of his symptoms, his counsel argued, but it might also sedate him, and could make him appear disinterested in his trial or uncaring toward his victims. Likewise, the medication might make Weston restless, and unable to sit throughout his trial; this could unnerve the jurors, or make the jurors fear him.³¹ Either set of symptoms, they contended, could impair Weston's ability to interact with his lawyers—in what might well be a trial for his very life.³²

Russell Weston faced the unenviable choice of taking psychotropic medication prescribed by the government's doctors in order to treat his mental illness, or continuing to refuse such treatment. The first option may have led to a restoration of his competence,³³ which in turn could enable him to stand trial in a possible capital prosecution with what his attorneys have argued could be diminished opportunities to effectively

25. *United States v. Weston*, 206 F.3d 9, 11 (D.C. Cir. 2000). Weston's counsel were not permitted to attend either hospital hearing. *Id.* at 11-12.

26. *Id.*

27. *Id.*

28. *United States v. Weston*, 69 F. Supp. 2d 99, 107 (D.D.C. 1999)

29. *United States v. Weston*, 206 F.3d 9, 13 (D.C. Cir. 2000) (statement of government psychiatrist Dr. Sally Johnson).

30. *Weston*, 69 F. Supp. 2d at 107.

31. These issues were not considered until a *third* hearing before the trial court, following a second round of appeals, in which the district court took testimony from three additional government expert witnesses, a defense expert witness, and an independent expert witness. *United States v. Weston*, No. 98-357, 2001 U.S. Dist. LEXIS 2486, at *20-21 (D.D.C. Mar. 6, 2001).

32. *See id.* at *21-22.

33. While we will refer for clarity's sake to medication "to restore competence to stand trial," it should be understood that the determination of competence to stand trial is a legal one. Comprehensive treatment aimed at improving a defendant's functional abilities such that they are restored to competence to stand trial may include, but is by no means limited to, medication.

defend himself against such a prosecution. The second option, continuing to oppose mental health treatment being delivered by the government's own mental health experts (whom he may understandably mistrust, as they are part of the same government that is prosecuting him and may decide to seek his execution), might preserve his legal rights to be free from unwanted bodily intrusions and unwanted effects on his mental processes, and may keep him from being competent to stand trial for a potentially capital crime. However, it will indefinitely continue his hospitalization (notwithstanding his never having been committed) and, of course, it will keep the distressing symptoms of his severe mental illness from being treated and will allow them to worsen.³⁴

Weston's case presents a high-profile and high-stakes example of what is unfortunately a common and ever-growing problem: the involuntary psychotropic medication of criminal defendants with significant, and often unexamined, consequences for their legal cases.³⁵ What is noteworthy about Weston's case is that his counsel had secured an order staying any involuntary mental health treatment without court approval,³⁶ and that the trial court promptly followed up with further hearings after the hospital's administrative process.

Far more typical is the situation of many pretrial detainees, who may receive involuntary psychoactive medication after an administrative process even more skeletal than Weston's, with potentially significant impact upon their pending criminal cases. When a criminal defendant is not facing a potentially capital trial, or is not under the spotlight of having committed a crime in the nation's capitol building, far less attention may be given to the decision to medicate him. However, the decisions regarding involuntary medication are not any less important.

As important as these issues are, the quality of procedural rights in many jurisdictions afforded pretrial detainees subjected to involuntary psychoactive medication is ultimately a function of the procedures required by federal constitutional law, and these procedures, as well as the substantive standards by which the ultimate decision to medicate is made, are tragically unclear and unsettled.³⁷ The poor quality of procedural protections afforded pretrial criminal defendants presents a risk that criminal defendants whose competency to consent to or reject treatment, as well as whose competency to stand trial is in question, are being

34. *See Weston*, 2001 U.S. Dist. LEXIS 2486, at *17 (detailing Weston's increasingly delusional state since prior hearing).

35. A rough estimate of the number of pretrial criminal defendants in the United States who receive psychotropic medication is approximately 33,000. This figure is based on a 1998 estimate of 96,700 "mentally ill" persons being held in local jails, and a rate of mental health treatment with medication since admission of 34.1%. *See* PAULA M. DITTON, U.S. DEP'T OF JUSTICE, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 3,9 (Bureau of Justice Statistics Special Report, July 1999).

36. *Weston*, 55 F. Supp. 2d at 24.

37. *See* discussion *infra* Part I.A.

medicated with little or no decision making on their part, or with little opportunity for their counsel to address the potential impact on their legal cases.³⁸

The lack of procedural protections for criminal defendants who face involuntary psychotropic medication exists largely for three reasons.³⁹ First, the United States Supreme Court has refused to articulate a clear substantive legal standard which must be satisfied before involuntary medication can occur.⁴⁰ Second, what efforts the Court has made to articulate a standard have relied upon two different legal paradigms, neither of which fully captures the interests implicated in the situation. Drawing upon the *parens patriae* rationale, the Court has relied upon cases setting forth the rights of juveniles, and mentally ill and mentally retarded persons who have been committed and are subjected to involuntary treatment.⁴¹ Drawing upon an institutional security rationale,

38. While hard data concerning the rate of psychotropic medication of pretrial defendants is difficult to obtain, *see* discussion *infra* Part II.B., there is emerging anecdotal data concerning the effects of psychotropic medication on prison inmates, and some of this involves their descriptions of their experiences undergoing medication during trial. *See* Kathleen Auerhan & Elizabeth Dermody Leonard, *Docile Bodies? Chemical Restraints and the Female Inmate*, 90 J. CRIM. L. & CRIMINOLOGY 599, 604 (2000) (describing use of psychotropic medication as disciplinary tool in prisons, and that “the narratives [they] present . . . demonstrate [that] jail and prison inmates in the United States are frequently medicated *without* diagnosis or proper psychiatric and physical assessments”).

39. This Article addresses involuntary medication of defendants who are being detained. It is an undeniable, and intellectually unsupportable fact that criminal defendants who are not detained, and who are thus free to obtain or refuse mental health treatment—at their own expense—may thus avoid the entire issue. There is no principled reason that a criminal defendant who can post bail and thus obtain release prior to trial may be less likely to face involuntary medication than one who is jailed awaiting trial. A pretrial defendant on bond could be found not competent to stand trial, yet capable of being rendered competent through medication, and the government might seek to have such medication administered involuntarily. Such a process would eliminate the issues related to dangerousness and present simply a question of whether the defendant can constitutionally be forcibly rendered competent to stand trial.

40. The Court last considered involuntary psychotropic medication of the pretrial criminal defendant in *Riggins v. Nevada*, 504 U.S. 127, 135 (1992), in which six members of the Court held that due process was violated by involuntary medication of a criminal defendant without a finding of medical appropriateness and “overriding justification.” Whether this decision requires the government to meet the test of “strict scrutiny,” and show a compelling interest in having the defendant medicated and that medication is a narrowly tailored means to achieve that interest, or whether the standard is something less than “strict scrutiny,” is unclear. *See* Woodland v. Angus, 820 F. Supp. 1497, 1510 (D. Utah 1993) (“This is the total of the *Riggins* Court’s guidance on the issue.”).

41. *See Riggins*, 504 U.S. at 135-36 (citing *Addington v. Texas*, 441 U.S. 418 (1979), for the proposition that substantive due process would have been satisfied had government shown treatment medically appropriate and essential for defendant’s own safety or safety of others, considering less intrusive alternatives). In *Addington*, the Court held that involuntary civil commitment requires clear and convincing proof of both dangerousness and mental illness to satisfy due process. 441 U.S. at 432-33; *see also*

the Court has relied upon cases involving the pretrial rights of criminal detainees, who are subjected to various impositions on their liberty by virtue of their incarceration.⁴² In both contexts, the Court has recognized as a matter of “substantive” due process the fundamental, constitutional right to “liberty” that is implicated, although it has held that this liberty interest is not absolute in either set of cases.⁴³ Neither of these lines of cases, however, completely captures the constitutional interests implicated by involuntary medication of the pretrial criminal detainee.⁴⁴

The third source of this lack of protection is the confusion between the types of constitutional rights that involuntary medication implicates. Challenges to involuntary treatment involve both substantive and procedural due process questions: they involve restrictions on “liberty” through hospitalization or forced medication that must be justified

Youngberg v. Romeo, 457 U.S. 307, 317-18 (1982) (holding that an involuntarily committed, mentally retarded individual, has a substantive due process liberty interest in minimally adequate or reasonable treatment to ensure safety, and freedom from undue restraint); Vitek v. Jones, 445 U.S. 480, 487-89 (1980) (holding that the involuntary transfer of convicted felon to mental hospital implicates fourteenth amendment liberty interest); Parham v. J.R., 442 U.S. 584, 601 (1979) (holding that voluntary commitment of minors to mental hospitals implicates liberty interest of the children in avoiding confinement for unnecessary medical treatment).

42. See *Riggins*, 504 U.S. at 135 (citing *Harper*, 494 U.S. 210 (1990), for proposition that involuntary treatment of convicted inmate was constitutional where inmate was dangerous and treatment was in inmate’s medical interest, and *Bell v. Wolfish*, 441 U.S. 520 (1979), for the proposition that rights of pretrial detainees are at least those enjoyed by convicted inmates).

43. See, e.g., *Addington*, 441 U.S. at 425 (“This Court repeatedly has recognized that civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.”); *Youngberg*, 457 U.S. at 320.

The question then is not simply whether a liberty interest has been infringed but whether the extent or nature of the restraint or lack of absolute safety is such as to violate due process In determining whether a substantive right protected by the Due Process Clause has been violated, it is necessary to balance “the liberty of the individual” and “the demands of organized society.”

Id. Further complicating this jurisprudence is the decision in *Kansas v. Hendricks*, 521 U.S. 346, 352, 360 (1997), in which the Court upheld the constitutionality of involuntary commitment (which it characterizes as “treatment”) after a defendant has already served his sentence.

44. As do those subjected to restrictions based on a *parens patriae* rationale, pretrial criminal detainees have interests in preserving their own bodily integrity from unwanted intrusions, preserving their mental functions from unwanted alteration, and preserving their own communicative ability from unwanted alteration, all of which combine to create a substantive due process interest in “liberty,” which is implicated by involuntary medication. See *Youngberg*, 457 U.S. at 316; *J.R.*, 442 U.S. at 600-01, cited in *Harper*, 494 U.S. at 222. These interests do not reflect the interests that pretrial detainees also have in enforcing their trial-related constitutional rights, which courts have viewed as potentially affected by psychotropic medication. See *Riggins*, 504 U.S. at 140-44 (Kennedy, J., concurring); see also *Weston*, 206 F.3d at 17 (Rogers, J., concurring) (“[U]ntil he is convicted, Weston’s rights and the relevant issues must be viewed through a somewhat different prism than those for a convicted prisoner.”).

according to some substantive standard,⁴⁵ and they involve procedures that may or may not be “due” the individual whose liberty may be restricted.⁴⁶ Because of the way in which involuntary medication issues have arisen the last two times the Court has considered them, however, these questions have been conflated.

The first time the Court considered the issue of involuntary psychotropic medication of a criminal defendant was in *Washington v. Harper*.⁴⁷ There, it examined both substantive and procedural due process questions arising from an administrative decision by a prison psychiatric board to involuntarily medicate a dangerous convicted inmate.⁴⁸ In *Harper*, the Court recognized the core substantive due process right implicated by involuntary psychotropic medication—even for a defendant who had already been convicted and who unquestionably presented some threat.⁴⁹ It concluded, however, as a matter of substantive due process, that the imposition on liberty was justified based upon the needs of correctional management, and that the process used to determine the need for medication was adequate, given the limited procedural rights accorded convicted inmates.⁵⁰

The last time the Court examined the issue of involuntary psychotropic medication of a criminal defendant, in *Riggins v. Nevada*,⁵¹ the context was not prison management of a convicted inmate approved by an administrative body. Instead, it was the involuntary medication of a defendant who had yet to be convicted, that was during a criminal trial, and approved by the trial court judge.⁵² The Court explicitly refrained from addressing the ultimate substantive due process question—whether involuntary medication could be justified solely to establish competence to stand trial—and held that the record was insufficiently developed to determine whether medication was justified in

45. See, e.g., *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992) (“Due Process Clause contains a substantive component that bars certain arbitrary, wrongful government actions ‘regardless of the fairness of the procedures used to implement them.’”) (citing *Zinermon v. Burch*, 494 U.S. 113, 125 (1990)).

46. See, e.g., *Jackson v. Indiana*, 406 U.S. 715, 738 (1972) (holding that due process requires commitment procedure for determining whether incompetent defendant could continue to be held beyond period required to determine or establish competence to stand trial); *Foucha*, 504 U.S. at 86 (finding a procedural due process violation where the commitment of an insanity acquittee continued without a showing by clear and convincing evidence of continued dangerousness).

47. 494 U.S. 210 (1990).

48. *Id.* at 220-21 (distinguishing substantive and procedural due process claims of convicted inmate subject to involuntary medication).

49. *Id.* at 221-22.

50. *Id.* at 135-36.

51. 504 U.S. 127 (1992).

52. *Id.* at 138 (holding substantive due process violation from involuntary medication of criminal defendant during trial, and remanding for hearing by trial court to assess whether government could justify involuntary medication).

the particular case.⁵³ No procedural due process claim was presented, because the defendant could not have had more “process” than that provided by a hearing before the trial judge.

Taken together, these two decisions establish a substantive due process “liberty” interest in freedom from involuntary medication for the pretrial criminal detainee, but delineate no clear framework for the standard to be applied in evaluating the imposition on liberty in any particular case.⁵⁴ Similarly, they establish that some procedure is due before involuntary medication can occur, but are unclear as to exactly what it is, and how much it can differ from the trial itself.⁵⁵ Thus the basic procedural questions that attend any imposition on individual rights, such as whether the decision maker must be a judge or may be an administrator, what form of hearing is required, what adversarial rights—such as counsel, cross examination and confrontation—exist and what evidentiary standard is used, are still unsettled questions.⁵⁶ More recent

53. *Id.* at 135-36.

54. *See, e.g.*, *Harrison v. State*, 635 So. 2d 894, 905 (Miss. 1994) (“Thus, although [*Riggins*] absolutely mandates that certain findings be made, it does not enlighten us as to exactly what those findings must be.”).

55. There are two principal candidates for the test used in deciding whether a particular procedural requirement or protection for the individual should be required. A “general approach for testing challenged state procedures under a due process claim,” *J.R.*, 442 U.S. at 599, is that set forth in *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976) (holding that in deciding whether procedural protection for the individual is required, the court considers the private interests at stake in a governmental decision, the governmental interests involved, and the value of the procedural requirements). However, an alternative test which the Court has indicated appropriate in procedural due process challenges to state criminal procedures is that of *Patterson v. N.Y.*, 432 U.S. 197 (1977). *See, e.g.*, *Medina v. California*, 505 U.S. 437, 446 (1992) (holding that due process is not violated by requiring defendant prove incompetence to stand trial by a preponderance of the evidence). *Patterson* permits state criminal rules so long as they do not “offend some principle of justice so rooted in the traditions and conscience of our people as to be ranked fundamental.” *Patterson*, 432 U.S. at 202 (quoting *Speiser v. Randall*, 357 U.S. 513, 523 (1958)). The prohibition on trying an incompetent defendant is doubtless fundamental, as is the premise that there are only narrow exceptions to the rule that bodily integrity—compromised by involuntary treatment—is a basic right of the individual. This test may be uninformative, however, as there is no real historical precedent concerning psychotropic medication.

56. The questions are not only unsettled but are being decided in conflicting ways by lower courts. *Compare* *United States v. Brandon*, 158 F.3d 947, 956 (6th Cir. 1998) (requiring adversarial judicial hearing before involuntary medication of pretrial criminal defendant) *with* *United States v. Morgan*, 193 F.3d 252, 265 (4th Cir. 1999) (rejecting *Brandon’s* requirement for judicial hearing and holding nonadversarial administrative proceeding before psychiatrist at prison hospital satisfied due process). *Weston* is an excellent example of this confusion. *See Weston*, 206 F.3d at 15 (Henderson, J., concurring) (ruling substantive due process requires no showing by government beyond “reasonableness” to involuntarily medicate defendant, and procedural due process requires no more than decision which is not arbitrary and capricious or an abuse of discretion); *id.* at 20 (Tatel, J., concurring) (ruling that substantive due process requires that the government show it can involuntarily medicate a defendant without impairing his right to a fair trial); *id.* at 18 (Rogers, J., concurring) (rejecting “reasonableness” as standard for

trial and appellate level cases involving involuntary medication of pretrial criminal detainees have made clear that these procedural due process questions that arise when the medication occurs through the administrative decision of a hospital or prison are at least as important—if not more so—than the ultimate substantive due process question⁵⁷ concerning what the government must show to justify involuntary medication.⁵⁸

The importance of the procedural due process issue stems from the fact that the decision to hospitalize or “commit” a criminal defendant could circumvent the defendant’s ability to contest medication. An involuntarily hospitalized person may in some cases be treated (including with medication) when such treatment is “deemed necessary to prevent the patient from endangering himself or others.”⁵⁹ Pretrial criminal detainees may be involuntarily hospitalized when their untreated mental illness renders them a danger to themselves or others. An administrative finding of “dangerousness,”⁶⁰ and the need for treatment, therefore, could vitiate all of the substantive limitations upon involuntary medication.

substantive due process inquiry, and ruling it requires “searching inquiry” into availability of less intrusive alternatives sufficient to control dangerousness, establish competency to stand trial and risk of impermissibly interfering with defendant’s right to fair trial, effective assistance of counsel, and freedom from bodily invasion).

57. Courts that have attempted to discern a substantive rule in *Riggins* have concluded that whatever the rule is, it is not absolute. See *Woodland v. Angus*, 820 F. Supp. 1497, 1510 (D. Utah 1993) (“Significantly, however, the foregoing makes clear that the [Supreme] Court will not necessarily permit the involuntary medication of every pretrial detainee, even if less intrusive means are not available for achieving competency.”); see also *State v. Garcia*, 658 A.2d 947 (1995). *Garcia* held that the involuntary medication of a murder defendant solely to achieve competence could be an “overriding justification” under certain circumstances, but noted the ambiguity left by *Riggins*’ description of the burden:

It is unclear whether the Supreme Court, in using the word ‘might,’ intended to reserve the issue of whether the state can justify involuntary treatment to restore a defendant to competency for the sole purpose of bringing him to trial, or whether the Court intended the word ‘might’ to indicate that such treatment is justified, but only if certain conditions are met.

Id. at 962.

58. See, e.g., *Morgan*, 193 F.3d at 255-57 (describing an unsuccessful procedural due process challenge to Bureau of Prisons regulation under which pretrial criminal defendant charged with drug and firearms offenses, found not competent to stand trial, was involuntarily medicated “as a preventive measure,” because he was assumed to “pose a potential risk to staff” based on the “violent nature” of the charges against him and his “anger and animosity” toward those proposing that he be medicated, notwithstanding the “incidental effect” of his thereby being made competent); *Brandon*, 158 F.3d at 956 (describing a successful procedural due process challenge to same Bureau of Prisons regulation by defendant charged with sending threatening letter who was found not competent to stand trial but was not found to be dangerous, whom the government sought to medicate as an “incident of his institutionalization”).

59. *Rennie v. Klein*, 720 F.2d 266, 269 (3d Cir. 1983).

60. “Dangerousness” is a much more complex concept than the much narrower test of competence to stand trial. Dangerousness, unlike competence, does not address

The Court's incomplete approach to the problem, involving reliance upon fundamentally insufficient models, is daily becoming more inadequate because the arguments do not incorporate information about recent developments in certain classes of drugs used to treat persons who might otherwise be incompetent to stand trial.⁶¹ An important aspect of the degree of imposition on constitutional rights posed by involuntary medication are beliefs that courts have held concerning the side effects the medications caused, both because of their feared potential for direct harm to the person medicated⁶² and because of their potential for indirect harm to the person's legal interests through the impact these side effects could have on decision makers (such as jurors) who observe defendants suffering from them.⁶³

Newer drugs, which appear to lack some of the most onerous side effects of past medications, and which are being used with greater frequency, will force the Court to revisit the questions surrounding involuntary medication in the near future.⁶⁴ When it does so, the Court should recognize the fundamental legal—as well as medical—character of the decision to undertake involuntary treatment of the pretrial criminal defendant with psychotropic medication.⁶⁵ It should also recognize that

particular functional abilities, or risks in a particular context. Relatively new risk assessment instruments are now being developed that may change this. See Henry J. Steadman, *From Dangerousness to Risk Assessment of Community Violence: Taking Stock at the Turn of the Century*, 28 J. AM. ACAD. PSYCHIATRY & L. 265, 268 (2000).

61. See notes 233-239.

62. See *Riggins*, 504 U.S. at 134 (citing *Harper*, 494 U.S. at 229) (“While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects.”).

63. See *id.* at 137 (“It is clearly possible that such side effects had an impact upon not just Riggins’ outward appearance, but also the content of his testimony on direct or cross examination, his ability to follow the proceedings, or the substance of his communication with counsel.”). The Court in *Riggins* identified various side effects that could harm defendants in different ways. *Id.* at 142-43. Defendants who under medication appear sleepy, dazed, or “out of it,” in the face of testimony concerning grisly details of their cases, risk appearing heartless and uncaring. *Id.* at 143-44. Other defendants, whose reactions to medication might include restlessness or involuntary spasms and jerking, risk frightening jurors with their behavior. See *id.* Moreover, a wide range of side effects, such as nausea, fatigue, lightheadedness, constipation, changes in blood pressure or the inability to concentrate, could all affect a defendant’s ability to effectively participate in the trial of his case. *Id.* at 144.

64. See Debra A. Pinals & Peter F. Buckley, *Novel Antipsychotic Agents and Their Implications for Forensic Psychiatry*, 27 J. AM. ACAD. PSYCHIATRY & L. 7 (1999). For a definition of the drugs we are describing as psychotropic, see *infra* Part II.A.

65. A few courts have begun to recognize this aspect of involuntary medication in the context of the pretrial criminal defendant. See, e.g., *Brandon*, 158 F.3d at 960 (“This legal determination [whether forced medication of defendant would render him competent to participate in a trial fair to both parties] is distinct from the medical determination [whether proposed treatment is least restrictive and least harmful way of rendering defendant competent].”).

absent an emergency,⁶⁶ the government should not be able to involuntarily medicate a pretrial criminal detainee with psychotropic drugs without first satisfying a judge that it has a compelling interest in doing so. In a very narrow class of cases the restoration of competency to stand trial may be such a compelling interest, but in keeping with previously established precedent, the Court should also require a showing that treatment with involuntary psychotropic medication is the most narrowly tailored means available to achieve this legitimate state interest. When the government is able to meet this standard, the Court should make clear that concurrent protective measures of the defendant's trial-related rights are constitutionally required.

This Article presents an outline of considerations for addressing the constitutional questions presented by involuntary medication of the pretrial criminal detainee, and suggests several components for a new standard upon which the Court might settle. Part I reviews the conflict in the jurisprudence resulting from *Riggins v. Nevada*, and highlights the two principal viewpoints that have arisen concerning the process which is due a pretrial criminal defendant subjected to involuntary psychotropic medication. These viewpoints may be characterized as treating all questions of involuntary medication similarly (under a "uniform model") or treating questions of involuntary medication of pretrial defendants differently from treatment of convicted inmates or committed persons (under a "functional model").⁶⁷ Part II sketches basic changes in the treatment of mental illness and the delivery of mental health services over the past decade, which combine to make the issue of involuntary medication more pressing, including most significantly the development of the "novel antipsychotic" medications. Part III outlines how the basic autonomy principle underlying the criminal justice system is implicated by involuntary psychotropic medication of the criminal defendant, and explains how involuntary medication raises issues concerning both the substantive limits to involuntary medication and the procedural

66. Emergency commitment and treatment—including with psychotropic medication—of those who pose an imminent threat to themselves or others by reason of their mental condition—is available in all states. *See generally* GARY B. MELTON ET AL., *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS* §10.04(a)(1), at 313-14 (2d ed. 1997). Pretrial criminal defendants are no exception, and a defendant who poses an imminent threat to herself or others in the trial process can be kept from causing harm, either by emergency medication and/or through commitment.

67. These viewpoints are analogous to "treatment-driven" and "rights-driven" analyses of cases involving involuntary medication identified over ten years ago by Dr. Paul S. Appelbaum. *See* Paul S. Appelbaum, *The Right to Refuse Treatment With Antipsychotic Medications: Retrospect and Prospect*, 145 J. PSYCHIATRY 4 (1988). Appelbaum's analyses, which considered the different approaches criminal and civil courts took to involuntary medication, prove to be particularly applicable for comparing the two dominant views of involuntary medication and the pretrial criminal detainee.

requirements for its implementation. Part IV identifies core principles, already well-established in the Court's existing jurisprudence, which could be used to resolve this conflict.

I. TWO LEGAL MODELS FOR EVALUATING INVOLUNTARY MEDICATION OF THE CRIMINAL DEFENDANT

Under what circumstances can criminal defendants who, because of mental illness, are not competent to stand trial without psychotropic medication,⁶⁸ be forced to take medication? While it has been clearly constitutional for some time to subject a potentially dangerous mentally ill prison inmate⁶⁹ or judicially committed person⁷⁰ to involuntary psychotropic medication, the constitutionality of involuntarily medicating persons who have not yet been adjudicated incompetent to make treatment decisions, and who have not yet been convicted of a crime, or who have not been judicially committed, is much less clear.⁷¹ The United States Supreme Court has refrained from deciding the question,⁷² and lower courts have split over the substantive showing necessary to justify the imposition on liberty, other substantive constitutional rights that involuntary medication carries with it,⁷³ and the procedure that is due a

68. Our focus is on medications explicitly designed to address disorders or conditions of the mind. A huge range of medications affect, in some sense, one's disposition—at least indirectly—by acting upon physiological conditions. Psychotropic medication, however, has “a special action upon the psyche.” MELTON ET AL., *supra* note 66, at 638. It is most commonly associated, at least in the context of litigation concerning its involuntary administration, with a particular class of antipsychotic medications: the phenothiazine derivatives. *Id.* at 636. This “group of psychotropic drugs include[s] Thorazine, Stelazine, Haldol, Mellaril, and Prolixin and can cause side effects such as Akathisia, Dystonia, and Tardive Dyskinesia.” *Id.*

69. *Washington v. Harper*, 494 U.S. 210, 225-26 (1990) (holding that due process is not violated by involuntary psychotropic medication of mentally ill prison inmate, who was a danger to himself, where decision to do so was professional medical judgment and review procedure permitted inmate to challenge decision, present evidence and cross examine witnesses).

70. *Klein*, 720 F.2d at 269 (requiring that decision to involuntarily medicate committed persons be a professional medical judgment); *see also* *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983).

71. *Mills v. Rogers*, 457 U.S. 291 (1982).

72. *See* discussion *infra* Part § I.A.

73. *Compare, e.g., Garcia*, 658 A.2d at 966-67 (outlining five prong balancing test requiring that treatment, to reasonable degree of medical certainty, will render defendant competent, not present unreasonable risk to defendant's health, be the least intrusive means to achieve adjudication of guilt or innocence, be narrowly tailored to limit intrusion on defendant's liberty and privacy interests, not cause unreasonable risk to defendant's health, and that seriousness of alleged crime be such that government's interests in establishing competency outweigh defendant's interests considering nature of defendant's illness, probability of successful treatment, risk of harm to defendant and potential side effects), *with Morgan*, 193 F.3d at 262 (requiring only that decision be medically appropriate professional judgment, though noting possible further procedural

criminal defendant before the medication decision is made—even as to such basic questions as the nature of the proceeding required⁷⁴ and the burden of proof.⁷⁵ The analyses of these questions by lower courts can be distinguished on the degree to which they recognize involuntary medication of a pretrial criminal defendant as distinct from involuntary medication of these other groups. After a review of *Riggins v. Nevada*, this Article goes on to describe the two general models lower courts have used to analyze the substantive and procedural due process issues presented by involuntary medication of the pretrial criminal defendant.

A. *Riggins v. Nevada and Unanswered Questions*

The United States Supreme Court has held that the liberty interest of a mentally ill person may be constitutionally restricted, consistent with substantive due process, if the person is found to be mentally ill and dangerous,⁷⁶ and if certain procedural requisites for making the determination are followed.⁷⁷ The Court has also held that the liberty

protections if medication occurs during trial that might affect his demeanor or trial-related rights).

74. Compare *Brandon*, 158 F.3d at 956 (requiring adversarial judicial hearing before involuntary medication of pretrial criminal defendant), with *Morgan*, 193 F.3d at 265 (rejecting *Brandon's* requirement for judicial hearing and holding nonadversarial administrative proceeding before psychiatrist at prison hospital satisfied due process).

75. Compare, e.g., *Garcia*, 658 A.2d at 966-67 (state must establish elements by clear and convincing proof), *State v. Odiaga*, 871 P.2d 801, 804 (1994) (burden on state rather than defendant to satisfy *Riggins* test, although burden not specified), and *Brandon*, 158 F.3d at 961 (government must prove case by clear and convincing evidence), with *Morgan*, 193 F.3d 252.

76. *Foucha*, 504 U.S. at 80 (holding that substantive due process prohibited continued confinement for treatment of insanity acquittee who was not mentally ill, and procedural due process prohibited scheme requiring such acquittee to prove he was not dangerous, notwithstanding a lack of mental illness); *Addington*, 441 U.S. at 431-33 (holding due process required at least clear and convincing proof of both mental illness and the need for hospitalization for patient's own welfare and that of others before involuntary civil commitment to mental hospital). Whether the substantive due process limitation in *Foucha* is still applicable may be open to question after the Court's ruling in *Hendricks*, 521 U.S. 346.

77. The Court first identified the substantive and procedural interests implicated by involuntary medication in *Mills v. Rogers*, 457 U.S. 291 (1982), a civil case challenging involuntary treatment of committed persons.

The principal question on which we granted certiorari is whether an involuntarily committed mental patient has a constitutional right to refuse treatment with antipsychotic drugs. This question has both substantive and procedural aspects. The parties agree that the Constitution recognizes a liberty interest in avoiding the unwanted administration of antipsychotic drugs. Assuming that they are correct in this respect, the substantive issue involves a definition of that protected constitutional interest, as well as identification of the conditions under which competing state interests might outweigh it. The procedural issue concerns the minimum procedures required by the

interest in avoiding unwanted treatment extends to those who have been convicted of crimes,⁷⁸ and requires that certain procedural requisites be followed before such persons may be subjected to involuntary mental health treatment.⁷⁹ These procedural requisites (at least for those who have already had a full criminal trial) may be far less demanding than what is required at a trial,⁸⁰ because the trial itself has been some proxy for a determination of dangerousness or mental illness.⁸¹ Prior to trial, this is not the case. In addition to a person's substantive right to avoid unwanted treatment, a pretrial criminal defendant has additional trial-related rights that must be protected.

In 1992, in *Riggins v. Nevada*,⁸² the Court faced but avoided deciding whether, absent a showing of imminent harm to himself or others,⁸³ a criminal defendant could be forcibly medicated for the sole purpose of attaining competence to stand trial.⁸⁴ The Court, however,

Constitution for determining that the individual's liberty interest actually is outweighed in a particular instance.

Id. at 298-99; *see also J.R.*, 442 U.S. at 607 (holding due process permits involuntary commitment of juveniles through independent evaluation by physician, after interview with child, without either formal or informal hearing or judicial oversight).

78. *See Vitek*, 445 U.S. at 494 (holding due process precluded state prisoner's involuntary transfer to mental hospital based only upon determination by physician or psychologist that inmate needed treatment unavailable in prison, without notice, opportunity for hearing, opportunity for confrontation and cross examination, opportunity to present witnesses, and an opportunity to have determination made by an independent decision maker). A plurality in *Vitek* also required that counsel be provided in such hearings. *Id.* at 497.

79. *Id.*

80. *See Foucha*, 504 U.S. at 80; *Jones v. United States*, 463 U.S. 354, 366 (1983) (holding finding of not guilty by reason of insanity sufficient foundation for commitment of insanity acquittee for purposes of treatment and protection of society). *But see Baxstrom v. Herold*, 383 U.S. 107, 110 (1966) (holding equal protection precludes involuntary commitment of prison inmates without review by jury trial, where such review is available to other committed persons).

81. *See Jones*, 463 U.S. 354; *see also Hendricks*, 521 U.S. at 356 (upholding post-sentence commitment of "dangerous sexual predators" based upon finding of dangerousness and proof of mental abnormality).

82. 504 U.S. 127 (1992).

83. This presumed that the defendant was not otherwise susceptible to involuntary medication, through, for example, his meeting the standards for commitment.

84. In *Riggins*, the Court characterized the ultimate issue this way: "The question whether a competent criminal defendant may refuse antipsychotic medication if cessation of medication would render him incompetent at trial is not before us." 504 U.S. at 136. Whether the defendant has the right to refuse the medication is the corollary of the government having the authority to involuntarily medicate to achieve competence, and facing either version of the ultimate question is an inevitable consequence of formulating procedures for identifying and weighing the interests involved. The question can arise in either "direction," i.e., as an effort by the defendant to end or maintain psychotropic medication. *See, e.g., Smith v. Moore*, 137 F.3d 808, 818 (4th Cir. 1998) (defendant unsuccessfully sought to continue antipsychotic medication before and during trial to maintain competence, and subsequently challenged his competence to have stood trial because he was taking antipsychotic medication).

ensured that the issue would ultimately reappear by finding that the practice of involuntary psychotropic medication implicated certain constitutional rights of the criminal defendant.⁸⁵ Besides avoiding the ultimate constitutional question, the Court also expressly declined to specify under what circumstances involuntary psychotropic medication of a pretrial defendant could occur—that is, what substantive standard the government would have to meet in order to justify involuntary medication.⁸⁶ The Court also indicated nothing about what procedure was required before such a decision is made.⁸⁷

Riggins involved a capital defendant who sought to be removed from antipsychotic medication for his trial; he intended to present an insanity defense, and planned to show the jurors his unmedicated mental

85. All three of the opinions in the case were in agreement with this proposition. *See Riggins*, 504 U.S. at 135 (O'Connor, J.) (“Fourteenth Amendment affords at least as much protection to persons the State detains for trial [as *Harper* does for convicted inmates]”); *id.* at 154 n.4 (Thomas, J., dissenting) (“A State, however, might violate a defendant’s due process right to a fundamentally fair trial if its administration of medication were to *diminish* substantially the defendant’s mental faculties during the trial, even if he were not thereby rendered incompetent.”); *id.* at 139 (Kennedy, J., concurring):

[O]ne who was medicated against his will in order to stand trial may challenge his conviction. When the state commands medication during the pretrial and trial phases of the case for the avowed purpose of changing the defendant’s behavior, the concerns are much the same as if it were alleged that the prosecution had manipulated material evidence

Id.

86. The majority explained:

Although we have not had occasion to develop substantive standards for judging forced administration of such drugs in the trial or pretrial settings, Nevada certainly would have satisfied due process if the prosecution had demonstrated, and the District Court had found, that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of *Riggins*’ own safety or the safety of others. Similarly, the State might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of *Riggins*’ guilt or innocence by using less intrusive means.

Id. Compare id. at 139 (Kennedy, J., concurring) (“extraordinary showing” by state required to satisfy due process), *with id.* at 155-57 (Thomas, J., dissenting) (rejecting the idea that existing law required that there be no less intrusive means of establishing competence or that it required more than reasonableness).

87. The Court had previously declined to specify the procedures required before involuntary medication of an incarcerated prisoner in *Harper*, 494 U.S. 210, holding only that a procedure involving notice to the inmate, and rights to be present, cross examine and present witnesses, but not to have counsel, was sufficient notwithstanding the lack of outside or impartial review. *Id.* at 220; *see also* Henry A. Dlugacz, *Riggins v. Nevada: Towards a Unified Standard for a Prisoner’s Right to Refuse Medication?*, 17 L. & PSYCHOL. REV. 41, 45 (1993) (noting that the “Supreme Court did not provide the lower courts with clear guidelines in movement from ‘right to treatment’ to ‘right to refuse’ involuntary medication in civil context”).

state.⁸⁸ The defendant's motion to be removed from this medication before trial was denied, although no finding was ever made that this would render him not competent to stand trial.⁸⁹ The Court narrowly delineated the issue by eliminating two procedural questions and two substantive questions. First, the Court noted that once Riggins's motion to be removed from medication was denied, any further medication could be presumed "involuntary."⁹⁰ Second, it presumed that the administration of the medication—notwithstanding any risks it posed—was "medically appropriate."⁹¹ The Court excluded from consideration any claim under the Eighth Amendment (which the Court held had not been presented below)⁹² as well as the claim that substantive due process had been violated by forcing Riggins to take medication as the only means of establishing his competency to stand trial.⁹³ What remained were questions concerning the substantive due process interest in liberty implicated by involuntary medication, the procedural due process questions of what protections were required in making the decision to medicate, and—most significantly for the pretrial defendant—any constitutional issues raised by virtue of the medication's possible interference with the criminal trial process.

The Court unanimously agreed that substantive due process is implicated by involuntary medication.⁹⁴ Drawing upon reasoning from the institutional security cases, which it had imported into *Washington v. Harper*, the Court explained in a remarkably casual way that involuntary medication to ensure the safety of a defendant or others was permissible.⁹⁵ The Court's analysis followed an implicit syllogism: due process affords prison administrators considerable deference in their decisions concerning institutional safety; this deference extends to permitting them to involuntarily medicate based only upon a reasonableness standard (i.e., that their decision was reasonably related to

88. 504 U.S. at 130.

89. *Id.* at 131.

90. *Id.* at 133.

91. *Id.*

92. *Id.*

93. *Id.*

94. *See id.* at 137 ("The [trial] court did not acknowledge the defendant's liberty interest in freedom from unwanted antipsychotic drugs."); *see also id.* at 139 (Kennedy, J., concurring) ("[A]bsent an extraordinary showing by the State, the Due Process Clause prohibits prosecuting officials from administering involuntary doses of antipsychotic medicines for purposes of rendering the accused competent for trial, and . . . [I] doubt that the showing can be made in most cases."); *id.* at 153 (Thomas, J., dissenting) ("The Court correctly states that Riggins, as a detainee awaiting trial, had at least the same liberty interest in avoiding unwanted medication that the inmate had in *Harper*").

95. *See id.* at 136 ("Nevada certainly would have satisfied due process if the prosecution had demonstrated, and the District Court had found, that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others.").

legitimate penological interests); therefore a substantially higher showing than “reasonableness” (i.e., that medication was “essential” for Riggins’ safety, considering less intrusive alternatives) *necessarily* meets the standard of reasonableness.

This syllogism oversimplifies the situation in a way that ignores three very important points. First, the courts have recognized that there is a critical relationship between involuntary medication and the trial process.⁹⁶ Psychotropic medication can affect the defendant’s ability to testify in his own defense, to interact with counsel, and to present his case in the most basic of ways.⁹⁷ Often, these effects may be largely positive, through improvement of the defendant’s ability to concentrate and organize his thoughts.⁹⁸ In *Riggins*, however, the Court indicated consequences of medication might have included drowsiness or confusion.⁹⁹ It noted how medication could have changed the jury’s perception of the defendant, and could have led the jury to conclude that the defendant was abnormally calm or even disinterested in the trial process, or conversely that the defendant was abnormally agitated and restless.¹⁰⁰ In short, the medication—whether normalizing or not—can affect both the defendant’s exercise of certain trial-related rights and the information before the finder of fact.

A second oversimplification of the syllogism equating *Harper* with *Riggins* is that involuntary medication is permissible in a prison or jail for institutional security reasons is either causally connected with, or necessarily susceptible to coordination with, the trial process. Neither is the case. Involuntary medication can be undertaken for different reasons (e.g., to remedy an emergency, to restore a defendant’s competence to make decisions about their own treatment, or to restore their competence to stand trial) that are causally unrelated. Thus, while medication for one purpose may have the *effect* of addressing another issue (such as when medication used to remedy an emergency has the incidental effect of restoring a defendant’s competence to stand trial), the incidental effect cannot be the *justification* for the medication. So, for example, the fact that a defendant can be rendered manageable for custodial purposes has nothing to do with whether she is able to participate in a trial. Finally, the syllogism overlooks the implications of medication on other fundamental constitutional rights that are unrelated to the trial process. These include

96. See, e.g., *In re Pray*, 336 A.2d 174, 177 (1975).

97. Thomas G. Gutheil, M.D., & Paul S. Appelbaum, M.D., “*Mind Control, “Synthetic Sanity,” “Artificial Competence,” and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*,” 12 HOFSTRA L. REV. 77, 100-18 (1983).

98. *Id.* at 117.

99. See *Riggins*, 504 U.S. at 137.

100. *Id.*

a right to be free from unwarranted intrusions to one's bodily integrity,¹⁰¹ and rights to freedom of speech and thought.

The Court also suggested in *Riggins*, albeit ambiguously, an alternative means of justifying medication that does address the trial process. Drawing upon a case that involved the trial court's authority to control the trial process, it explained "similarly" that a state "might" have been able to justify involuntary medication if it could not obtain an adjudication of guilt or innocence by using less intrusive means.¹⁰² Whether "might" means that a state could do this, if it could show that it could not adjudicate guilt or innocence using less intrusive means, or whether it means that the Supreme Court could, in a future case, accept such a justification is unclear.¹⁰³ What is clear, however, from this explanation, is that the Court went to pains to avoid either the well-defined "strict scrutiny"¹⁰⁴ standard for the imposition on a fundamental right, or the less well-defined standard of "intermediate scrutiny."¹⁰⁵

Apart from intentionally leaving undefined the substantive showing that must be made to involuntarily medicate a pretrial criminal defendant, the Court left unresolved two other issues, one substantive and one procedural. The procedural issue is mechanical: what procedure is due a defendant in the making of the involuntary medication determination? The question was not addressed because the trial judge in *Riggins* had made the decision to involuntarily medicate after an adversarial hearing in the trial court, employing the rules of evidence and all the conventional procedural safeguards at trial. Thus, *Riggins* could not have had more procedural due process than he got.¹⁰⁶ The more difficult question concerns the balance between other rights implicated by the criminal trial process and the state's interest in involuntarily medicating the defendant. The Court alluded to these issues, holding that the defendant's right to a fair trial, right to effective assistance of counsel, and right to testify in his own defense were not satisfied merely by permitting him to offer expert testimony on the effect of the medication on his demeanor, but only Justice Kennedy's concurring opinion fully explored the depth of these issues.¹⁰⁷

101. See, e.g., *Rochin v. California*, 342 U.S. 165 (1952).

102. See *Riggins*, 504 U.S. at 135.

103. See *Garcia*, 658 A.2d at 962:

It is unclear whether the Supreme Court, in using the word "might," intended to reserve the issue of whether the state can justify involuntary treatment to restore a defendant to competency for the sole purpose of bringing him to trial, or whether the court intended the word 'might' to indicate that such treatment *is* justified, but only if certain conditions are met.

Id.

104. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973).

105. See *Craig v. Boren*, 429 U.S. 190 (1976) (holding that sex-based classifications must be substantially related to an important government interest).

106. *Riggins*, 504 U.S. at 137.

107. *Id.* at 139-46 (Kennedy, J., concurring).

The relationship between the trial-related rights of a defendant and his involuntary psychotropic medication is multifaceted. Concerns about the effects of medication have been expressed with reference to a range of defendants' rights. Involuntary psychotropic medication, because it directly affects the thought process, necessarily affects a defendant's ability to testify in his own defense (protected by the Fifth and Sixth amendments),¹⁰⁸ to consult and interact with counsel (protected by the Sixth Amendment),¹⁰⁹ to comprehend the trial process (protected by due process), and to present an effective defense (protected by due process).¹¹⁰ If the defendant's case includes a defense of lack of criminal responsibility through mental disease, the defense might be affected by the medication's impact on his actions, demeanor, and speech in the court.¹¹¹ Medication may, nevertheless, improve a defendant's competence to stand trial. It may, for example, control hallucinations or delusions in a defendant who suffers from schizophrenia. These salutary effects of medication may not necessarily preclude effective presentation of a defendant's case—even one based on his mental state at the time of the offense. In fact, they may ameliorate the defendant's thought process such that he can provide more effective testimony. Additionally, his case may be presented through expert testimony, through other lay testimony

108. *Rock v. Arkansas*, 483 U.S. 44, 57-58 (1986) (holding that an absolute bar on hypnotically refreshed testimony by defendant would violate rights to personally conduct defense and to speak through unfettered exercise of his will).

109. *Woodland v. Angus*, 820 F. Supp. 1497, 1513 (D. Utah 1993) ("Medicating [defendant] with psychotropic medication might also interfere with [defendant's] right to cooperate with counsel in his defense.") (citing Sixth Amendment right in *Massiah v. United States*, 377 U.S. 201 (1964)). The right to actively cooperate with counsel in one's defense cannot be impaired by the government. *See Massiah*, 377 U.S. 201, 205-06 (holding that a surreptitious interview with defendant after indictment and obtaining counsel violated Sixth Amendment); *Gedders v. United States*, 425 U.S. 80, 91 (1976) (prohibition on overnight contact between defendant and counsel during trial recess violated Sixth Amendment).

110. *See, e.g., People v. Posby*, 574 N.W.2d 398, 400-01 (Mich. Ct. App. 1997) (holding trial court erred in denying motion of murder defendant, who relied upon insanity defense, to be removed from psychiatric medication—necessary to maintain competence—for three day period in which he would testify, noting "[t]his question really implicates defendant's right to present a defense.").

111. *See, e.g., Riggins*, 504 U.S. at 142 (Kennedy, J., concurring) ("It is a fundamental assumption of the adversary system that the trier of fact observes the accused throughout the trial, either while the accused is on the stand or sitting at the defense table."); *see also Taylor v. United States*, 414 U.S. 17 (1973) (per curiam). Numerous state courts have also recognized the problem. *See, e.g., Commonwealth v. Gurney*, 595 N.E.2d 320, 324 (Mass. 1992) ("It would not be unusual for a jury improperly to discredit such evidence [relating to a claim of diminished mental capacity] because the defendant appears to be perfectly sane at the time of trial due to the quieting effect of antipsychotic medication."); *In re Pray*, 336 A.2d 174, 177 (Vt. 1975) (Defendant's "deportment, demeanor, and day-to-day behavior during [his] trial, before [the jury's] eyes, is a part of the basis of their judgment with respect to the kind of person he really was [at the time of the crime], and the justifiability of his defense of insanity."); *Lawrence v. State*, 454 S.E.2d 446, 452 (Ga. 1995).

of those familiar with the defendant's unmedicated behavior, or through other evidence of his unmedicated behavior such as tapes or recordings.¹¹² These sources of evidence are not affected by his being medicated, although they may not be sufficient, and the defendant has a constitutional right to testify in his own defense should he so choose.

These are fact-based inquiries, however, and what must be considered is the fact that involuntary psychotropic medication impacts many critical trial-related rights, while impacting also on the potential for otherwise leaving a person untreated for a significant illness. It is undeniable that to leave a defendant who has a serious mental illness without treatment—or without the most effective treatment available—can impose very significant costs. Unfortunately, the Court did not specify how these impacts were to be weighed in a trial court's determination of the matter. It specified nothing about the process that would be required before a defendant could be involuntarily medicated, what burden of proof would be required, or even who would make the decision concerning involuntary medication—a judge or a physician. These procedural issues have not resolved themselves.

B. Two Models of Involuntary Medication of the Criminal Defendant

In 1983, Gutheil and Appelbaum reviewed two categories of legal decisions: criminal cases involving involuntary medication to treat mental illness and thereby restore the defendant's competence to stand trial, and civil cases involving the right of psychiatric patients to refuse treatment.¹¹³ They also reviewed existing studies of the effects of antipsychotic medications on behavior and thought, including both pathological and non-pathological (i.e., psychotic and normal) thought processes,¹¹⁴ and determined that with two important exceptions, the

112. See, e.g., *Lawrence*, 454 S.E.2d at 452 (holding that a defendant is entitled to present expert testimony and obtain jury instructions concerning effect of medication on his demeanor). Federal law actually provides a mechanism for such recordings, at least in federal criminal cases. 18 U.S.C. § 4247(f) (1999) ("Upon written request of defense counsel, the court may order a videotape record made of the defendant's testimony or interview upon which the periodic report is based pursuant to subsection (e)."). Curiously, this provision only authorizes recording of evaluation interviews for periodic reports—those made of persons who have been found not competent to stand trial under 18 U.S.C. § 4241, not guilty by reason of insanity, or who have been convicted of a crime but not yet sentenced and require care and treatment or persons imprisoned who need care and treatment. It does not appear that the provision would permit videotaping in the first instance of an initial evaluation. See U.S. CODE CONG. & ADMIN. NEWS, 98th Cong., 2d Sess. at 3436, P.L. 98-473 (1984).

113. See *generally* Gutheil & Appelbaum, *supra* note 97.

114. Gutheil and Appelbaum reviewed existing studies of the effects of antipsychotic medications on symptoms of mental pathology or disease ("Effects of Antipsychotic Medications on Psychotic Symptomatology") and on normal mental

principal effects of antipsychotics on mentation were normalizing.¹¹⁵ By and large, medication designed to control the symptoms of psychoses do just that. The two exceptions to this result concerned the tendency of the medications to produce the physical symptoms of akinesia¹¹⁶ and akathisia.¹¹⁷ They concluded that the legal decisions in the civil cases (which they characterized as “rights-driven”) significantly overemphasized and often overstated the effects of these medications on behavior and thought, while the decisions in the criminal cases (which they characterized as “treatment-driven”)—for whatever reason—more accurately and, in their opinion, objectively weighed the consequences of antipsychotic medication.¹¹⁸

The jurisprudential conflict concerning the involuntary psychotropic medication of a criminal defendant reflects two quite different views of the interests implicated by the practice, and mirrors the conflict in the Supreme Court itself.¹¹⁹ These views, which we characterize as the “uniform” and “functional” views, treat involuntary medication of the criminal defendant as either presenting a constitutional question that is essentially the same as that presented by involuntary medication of other

functions (“Non-Psychopathological Aspects of Mentation”). *Id.* at 100-18. The normal mental functions which they reviewed included memory, psychomotor functioning (muscular movement effects of mental processes), attention and perception, and other complex mental functions such as logic and problem solving. *Id.*

115. With regard to the effect of antipsychotic medications on psychotic symptoms, they concluded that “courts should have no hesitancy in acknowledging the demonstrated efficacy of antipsychotic medication in alleviating the symptoms of psychosis and in preventing their recurrence.” *Id.* at 118. With regard to the effects of the medications on normal mental processes, they cautiously concluded that “[b]ased on existing data, with one exception . . . such a mental impairment seems highly unlikely.” *Id.* The exception was psychomotor functioning—which may of course affect how a defendant is perceived in court.

116. Decreased movement and masking that may be perceived as apathy or disinterest.

117. A sense of motor restlessness, sometimes manifesting with increased movements and seen as agitation.

118. Gutheil & Appelbaum, *supra* note 97. This result was confirmed by Appelbaum in his 1988 analysis of these issues. Paul S. Appelbaum, M.D., *The Right to Refuse Treatment with Antipsychotic Medications: Retrospect and Prospect*, 145 J. PSYCHIATRY 4 (1988).

119. *Compare Riggins*, 504 U.S. at 135-36 (holding that state might have been able to justify medically appropriate involuntary treatment necessary to “obtain an adjudication of Riggins’ guilt or innocence,” notwithstanding that defendant’s constitutionally protected trial rights, including right to testify in one’s own defense, “follow the proceedings,” and communicate with counsel “may well have [been] impaired,” by trial court’s failure to acknowledge his liberty interest in freedom from involuntary antipsychotic medication), *with id.* at 145 (Kennedy, J., concurring) (opining that if defendant cannot be brought to trial without impairing trial-related rights of “unfettered exercise of his own will,” cooperation with counsel and reaction and response to the proceedings, “the Constitution requires that society bear this cost in order to preserve the integrity of the trial process”). *See also* *Khiem v. United States*, 612 A.2d 160, 177 (D.C. App. 1992) (dissenting from denial of rehearing en banc).

persons (hence “uniform”), or that is different because the medication impacts the functioning of the defendant’s trial-related rights (hence “functional”).¹²⁰ These views are modeled upon two legal approaches identified by Gutheil and Appelbaum nearly two decades ago, at the height of litigation concerning the right of mentally ill persons to obtain and to refuse treatment.

The conclusions Gutheil and Appelbaum drew in 1983 concerning the generally positive effects of the older versions of antipsychotics on behavior and thought are more pronounced today with the advent of the novel antipsychotics: the drugs have become more effective at normalizing thought with reduced side effects.¹²¹ However, the particular side effects that they identified as significant are especially important in the operation of the defendant’s trial-related rights. Specifically, when these side effects are observed by jurors who are determining a defendant’s mental state at the time of the crime, they can have a profound effect on the defendant’s ability to present his case.¹²² Lay fact

120. These views have also been characterized as those which demonstrate “sanist” assumptions and “pretextual thinking,” and those which do not. See MICHAEL PERLIN, *THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL* 134-35 (2000). Discussing the divide between these views, Perlin writes:

Why has the law developed as it has in this volatile area? The seemingly incoherent splits in right-to-refuse decision making can best be explained by considering these jurisprudential constructs. Judges who use heuristic devices, make sanist assumptions, and employ pretextual thinking decide cases that ignore social science data, privilege myths, and misstate established legal doctrine. Others, however, read social science data carefully, avoid sanist thought processes, and reject pretextual decision making.

The split between the panel and the *en banc* Fourth Circuit in *United States v. Charters* or the differences between the majority and dissent in *Riggins v. Nevada* perfectly mirror this dichotomy. *Id.* at 135.

121. Pinals & Buckley, *supra* note 64.

122. From a medical perspective, these side effects may seem minimal and, in theory, present no more of a challenge to the defendant who must convince the jury of his psychosis at the time of the crime despite his normal mental state by the time of trial. While perhaps true as a matter of logic, this analysis ignores the potential influence upon juror decision making of both observation of defendant (or any witness) and reaction to abnormal behavior.

The Supreme Court recognized these concerns in *Riggins*. See 504 U.S. at 137 (comparing possible prejudicial effects of involuntary medication to consequences of wearing prison clothing at trial); *id.* at 143-44 (Kennedy, J., concurring) (“[A]s any trial attorney will attest, serious prejudice could result if medication inhibits the defendant’s capacity to react and respond to the proceedings and to demonstrate remorse or compassion”).

Other courts have recognized this problem as well. “We recognize that the demeanor at trial of a criminal defendant is of probative value with respect to the defense of insanity.” *Lawrence v. State*, 454 S.E.2d 446, 452 (1995) (holding defendant entitled to have jury instructed at beginning and end of trial that defendant is under influence of medication, that defendant’s behavior is conditioned by it, and that defendant’s insanity is to be evaluated as of time criminal acts committed). See *also* FLA. R. CRIM. P.

finders confronted with bizarre, abnormal, or simply unfamiliar behavior, whether an expression of the illness itself or an effect related to the medication, may be significantly and negatively disposed toward those displaying it, notwithstanding a “logical” explanation for the behavior. On the other hand, abnormal behavior by a defendant may evoke sympathy from jurors, who would thus be more likely to render a decision favorable to the defendant. Consideration of the risk of visceral, irrational, or biased responses by jurors is, in fact, common in the legal system, and restricting or minimizing such effects is a core concern of the legal system’s evidentiary rules.¹²³

In addition to these effects, which can impact the defendant’s ability to present a defense, psychotropic medication can affect the defendant’s ability to exercise other trial-related rights, such as his right to interact with counsel and the right to testify in his own defense. It is this impact upon the defendant’s trial-related rights—which are recognized in the cases that adopt a “functional view”—that was beyond the scope of the Gutheil and Applebaum article, and which is the key distinction between the two views discussed below.

1. *UNITED STATES v. WESTON* AND THE UNIFORM AND FUNCTIONAL MODELS OF INVOLUNTARY MEDICATION

The case of Russell Weston provides excellent illustrations of both the uniform and functional views of involuntary medication of the criminal defendant. Under the uniform view,¹²⁴ the principal interests of the criminal defendant implicated by involuntary psychotropic medication are seen as the same as those of someone who has been involuntarily medicated, but has not been charged with a crime: the right to bodily integrity, or freedom from unwanted bodily intrusions,¹²⁵ and the right to

3.2145(C)(2) (“Effect of Adjudication of Incompetency to Proceed: Psychotropic Medication”); *In re* Amendments to Fla. Rules of Criminal Procedure, 536 So. 2d 992, 1002 (Fla. 1988).

123. See FED. R. EVID. 403 (stating that the general test for exclusion of otherwise relevant evidence, which permits exclusion if the “probative value [of the evidence] is substantially outweighed by dangers of unfair prejudice”). According to the Advisory Committee Notes, “[u]nfair prejudice’ within its context means an undue tendency to suggest decision on an improper basis, commonly, though not necessarily, an emotional one.” *Id.*, advisory committee’s notes.

124. See, e.g., *Khiem*, 612 A.2d 160; *United States v. Charters*, 863 F.2d 302 (4th Cir. 1988) (en banc), *reaffirmed* in *Hogan v. Carter*, 85 F.3d 1113 (4th Cir. 1996); *Donaldson v. Denver*, 847 P.2d 632 (Colo. 1993); *State v. Van Orden*, 647 N.E.2d 641 (Ind. 1995); *State v. Armstrong*, 649 So.2d 683 (La. 1994); *State v. Baker*, 511 N.W.2d 757 (Neb. 1994); *Adams*, 888 P.2d 1207.

125. The forcible injection of medication into a nonconsenting person’s body, “we said, ‘presents a substantial interference with that person’s liberty.’” *Riggins*, 504 U.S. at 134 (citing *Harper*); see also *Khiem*, 612 A.2d at 165 (“[T]he common law liberty interest in one’s own bodily integrity is an important one.”); *Charters*, 863 F.2d at 305 (en banc) (“the forcible administration of antipsychotic drugs presents a sufficiently

freedom from having one's mental processes altered.¹²⁶ The Court has characterized the latter interest implicated as a substantive due process interest in liberty, that is, a person's freedom from unwanted psychotropic medication can only be curtailed within certain limits.¹²⁷ Arrayed against the interest that anyone has in freedom from unwanted bodily intrusions, and the substantive right to be free of some degree of control of one's mental liberty, according to this view, are certain interests of the government: the interest in bringing a case to trial,¹²⁸ in prompt and final disposition,¹²⁹ in control of a possibly dangerous person and in maintenance of public safety.¹³⁰ This view does not distinguish the situation of the pretrial criminal defendant as raising different considerations from that of incarcerated or judicially hospitalized persons, or those hospitalized involuntarily after incarceration. Each of these situations is seen as presenting a uniform constitutional question.¹³¹ Thus

analogous intrusion upon bodily security to give rise to such a protectible liberty interest"), *reaffirmed in* Hogan, 85 F.3d at 1118. Some courts have simply characterized the interest as (presumably substantive) "due process," *Donaldson*, 847 P.2d at 634 ("[U]nconsensual [sic] treatment by antipsychotic drugs of a person detained for trial violates federal constitutional due process guarantees 'absent a finding of overriding justification and a determination of medical appropriateness'"); *Van Orden*, 647 N.E.2d 641; *Armstrong*, 649 So. 2d 683; *Baker*, 511 N.W.2d 757; *Adams*, 888 P.2d 1207.

126. While the Court has not clearly articulated a "right to treatment," see *O'Connor v. Donaldson*, 422 U.S. 563 (1975), one might argue that the Court should consider this interest in light of the fact that without treatment a defendant may languish in an unmedicated state.

127. *Riggins*, 504 U.S. at 134-35; *Harper*, 494 U.S. at 221-22.

128. See, e.g., *Woodland*, 820 F. Supp. at 1513 (noting that the "State of Utah clearly has a significant interest in trying those accused of murder"). See generally *Illinois v. Allen*, 397 U.S. 337, 347-48 (1970) (explaining that constitutional safeguards for criminal defendants "presuppose that government has a sovereign prerogative to put on trial those accused in good faith of violating valid laws [and that] Constitutional power to bring an accused to trial is fundamental to a scheme of 'ordered liberty' and prerequisite to social justice and peace"); see also *Winston v. Lee*, 470 U.S. 753, 762 (1985) ("[T]he community's interest in fairly and accurately determining guilt or innocence . . . is of course of great importance.").

129. See, e.g., *Barker v. Wingo*, 407 U.S. 514, 518 (1972) ("[T]here is a societal interest in providing a speedy trial which exists separate from, and at times in opposition to, the interests of the accused.").

130. The government has also raised the argument, in support of involuntary psychotropic medication, that *it* has an interest in ensuring treatment in the least restrictive environment. See *Woodland*, 820 F. Supp. at 1518 (rejected by court on the basis that government cited no legal precedent or evidence for this proposition).

131. Judicial hospitalization can of course occur prior to trial (for example because a defendant is not competent to stand trial) and the key distinction between the views is whether they recognize the hospitalized defendant's existing susceptibility to trial as distinguishing the situation or not. Compare *Woodland*, 820 F. Supp. at 1510-11 (noting significance of pending criminal case), with *Kulas v. CSO Valdez*, 159 F.3d 453, 455-56 (9th Cir. 1998) (holding no difference), and *Morgan*, 193 F.3d at 262-63 (holding that, in case of a defendant found not competent to stand trial, the *Harper* standard governs, and "the determination of whether to forcibly medicate a pretrial

issues peculiar to the situation of the criminal defendant, such as the ethical conflict posed by the combination of the prosecutor and medicator in a single authority, as when the defendant is detained prior to trial, are not considered fundamentally different.¹³²

Under the functional view,¹³³ the fact that the person being subjected to involuntary medication is a criminal defendant is seen as implicating a broader range of constitutionally-protected interests than simply the right to be free of unwanted bodily intrusions or the right to a certain degree of mental freedom. The liberty of the pretrial criminal defendant, about whom no legal determination concerning guilt (or, necessarily, the need for hospitalization¹³⁴) has been made, is at risk from the entire criminal process, not just from involuntary medication. The criminal defendant, by virtue of having been charged with a crime, also has certain unique procedural constitutional rights that arise in connection with a trial.¹³⁵

Both of these factors distinguish the situation of the pretrial defendant from that of the convicted individual. Moreover, the operation of psychotropic medication can—under this view—significantly affect the exercise of these trial-related constitutional rights. Rights that could potentially be affected include the right to effectively interact with counsel, the right not to be compelled to incriminate oneself, the right not to be forced to trial if one is not competent, and the right to present one's own view of the evidence. This last right, to present one's own view of the evidence, is particularly inhibited under this view when the defendant's mental state at the time of the crime is in issue, because psychotropic drugs can affect the defendant's own demeanor, reactions, or testimony, which may show something about his mental state at the time of an alleged crime.¹³⁶ This view embodies a basic distinction between the constitutional implications of the pretrial criminal defendant

detainee such as Morgan rests upon the professional judgment of institutional medical personnel, subject only to judicial review for arbitrariness”).

132. See, e.g., *Charters*, 863 F.2d at 315 (Murnaghan, J., dissenting); see discussion *infra* Part I.B.2(B).

133. See *generally* *United States v. Brandon*, 158 F.3d 947 (6th Cir. 1998); *Kulas*, 159 F.3d 453; *Woodland*, 820 F.Supp. 1497; *Garcia*, 658 A.2d 947; *State v. Odiaga*, 871 P.2d 801 (Idaho 1994); *Posby*, 574 N.W.2d 389; *Singelton v. State*, 437 S.E.2d 53 (S.C. 1993).

134. A pretrial criminal defendant can certainly have been committed, as in some of the cases reflecting either view. See, e.g., *Kulas*, 159 F.3d 453; *Woodland*, 820 F. Supp. 1497. We argue, however, that the legally dominant fact in the medication decision should be the defendant's status as a pretrial defendant, rather than his having been committed.

135. These include, most significantly in this context, the rights to testify (or not to do so) in one's own defense, to confront one's accusers, to present a defense and to have the effective assistance of counsel. See *infra* notes 183-186.

136. A defendant has a right, under the Confrontation Clause, to be physically present at his own trial. *Taylor v. United States*, 414 U.S. 17, 19 (1973). The defendant's demeanor, especially if he testifies, may also be relevant to his confrontation rights. See *Coy v. Iowa*, 487 U.S. 1012, 1016-20 (1988).

and those of other persons who may be involuntarily medicated, which focuses on the functions that may be affected by the medication in context.

These two views concerning the constitutionality of involuntary medication of a pretrial criminal defendant differ in more than just the substantive standard each employs to decide whether medication is permissible. Because the *Riggins* standard is somewhat unclear, the procedural due process question concerning how an involuntary medication decision can be made has become especially important. Here the difference between the uniform and functional views is more pronounced. It colors the procedures courts have found necessary before involuntary medication can occur, and the burden of proof they have required. Under the uniform view, involuntary psychotropic medication of a criminal defendant can occur with less procedural formality, upon a reduced showing by the government, than under the functional view.

The latest decision in Russell Weston's case provides a remarkable demonstration of the divergence between these views, and the strength with which adherents to each draw upon cryptic references in existing Supreme Court jurisprudence. The district court had upheld the Bureau of Prisons' decision to involuntarily medicate Weston on the grounds that it was "medically appropriate and that, considering less intrusive alternatives, it [was] essential for [Weston's] safety or the safety of others."¹³⁷ It had not reviewed the Bureau's other justification for medication, namely that it was necessary in order to render Weston competent to stand trial. The district court decision thus pretermitted the issue of involuntarily medication, finding it and the issue of the impact of involuntary medication on his Sixth Amendment right to a fair trial not yet ripe.¹³⁸

The appellate court panel of three judges issued an unsigned per curiam opinion, and three concurrences.¹³⁹ Applying *Riggins*, the panel held that it needed not decide either the applicable substantive due process standard or the applicable procedural due process standard, as no evidence supported the district court's purported basis for its decision.¹⁴⁰ The per curiam opinion recognized that the Supreme Court in *Riggins* had refused to provide either a substantive or procedural standard for the review, and noted that it preferred not to do so either.¹⁴¹ It also explained, however, that there was no evidence for the "dangerousness" basis for the medication decision, and that the competency basis for medication was

137. *Weston*, 69 F. Supp. 2d at 118.

138. *Id.* at 107.

139. *Weston*, 206 F.3d 9 (per curiam); *id.* at 14 (Henderson, J., concurring); *id.* at 15 (Rogers, J., concurring); *id.* at 19 (Tatel, J., concurring).

140. *Id.* at 12-13.

141. *Id.* at 12.

also ripe for decision on remand (albeit without benefit of a standard by which to decide the question).¹⁴²

The individual concurrences, however, present quite a different story. Judge Henderson held that the correct substantive standard for the imposition on liberty by involuntary medication is the same for a pretrial detainee as it is for a convicted inmate: “reasonableness.”¹⁴³ She also found that the procedural standard was simply the one that had been set forth in the Administrative Procedure Act for the review of agency action: it must not be “arbitrary, capricious, [an] abuse of discretion, or otherwise not in accordance with law.”¹⁴⁴ With respect to the degree to which consideration of Weston’s trial-related rights impacted the medication decision, Judge Henderson concluded that due process was satisfied simply by the potential availability at Weston’s future trial of lay and expert testimony concerning the effect of medication on Weston’s appearance and demeanor. Nothing more is required. Her opinion neatly summarized the uniform view.

Judge Rogers, by contrast, explained that while the substantive standard for involuntary medication of a pretrial defendant is unsettled, it is clearly something different than the “reasonableness” standard of *Washington v. Harper* that Judge Henderson identified.¹⁴⁵ Emphasizing the different (and more demanding) substantive standards the Court has applied to involuntary commitment of those who have not yet faced a criminal trial she concluded that “until he is convicted, Weston’s rights and the relevant issues must be viewed through a somewhat different prism than those for a convicted prisoner.”¹⁴⁶ She described the need for a “searching examination” of both the dangerousness and competency rationales, as well as the impact of

142. *Id.*

143. *Id.* at 14-15 (Henderson, J., concurring).

144. *Id.*

145. *Id.* at 17 (Rogers, J., concurring) (“While the [Supreme] Court stated that it was not adopting a standard of strict scrutiny, as it had ‘no occasion to finally prescribe such substantive standards’ . . . it nonetheless was clear that the Supreme Court did not simply apply the *Harper* standard.”); *see also* Sullivan v. Flannigan, 8 F.3d 591, 599 (7th Cir. 1993) (“It is worth noting, however, that *Riggins* requires something more than *Harper*. When the right to stand trial is at issue, the state must consider less intrusive alternatives to forcing drugs upon the accused.”).

146. *Weston*, 206 F.3d at 17. At least one court has found that *Riggins* also altered the substantive standard for medication of a convicted inmate. *See Kulas*, 159 F.3d at 455 (“To force antipsychotic drugs on a prisoner or on a detainee awaiting trial is impermissible under the federal constitution, ‘absent a finding of overriding justification and a determination of medical appropriateness.’”); *id.* at 458 (Wallach, J., dissenting) (“At the time of [defendant’s] alleged actions, the right of inmates in regard to forced medication had been clearly established in *Washington v. Harper* and *Riggins v. Nevada*.”).

involuntary medication, on Weston's trial-related rights.¹⁴⁷ These include, she noted, his "right to trial and counsel, to be free from bodily invasion, [as well as] the government's interests in protecting his and others' physical safety and in bringing him to trial."¹⁴⁸

Echoing Judge Rogers' opinion, Judge Tatel identified Weston's fair trial rights, guaranteed by the Fifth, Sixth and Fourteenth Amendments,¹⁴⁹ that could be affected by involuntary medication, and explained how the trial court must consider the impact of any side effects of medication—both on Weston's ability to implement his rights and on the jurors' perceptions of him.¹⁵⁰ Judge Tatel discussed in detail the type of questions the district would have to ask:

How likely is it that these side effects will actually occur? How severe are they likely to be? Can side effects be mitigated or controlled by reducing the dosage, changing the type of medication, or administering medication to counteract these effects, and if so, can this be accomplished without reducing the drugs' potential for controlling delusions? Considering the answers to such questions as well as Weston's previous experience with psychotropic drugs, the district court will have to determine whether it is likely that the drugs will so adversely affect Weston and the jury's perception of him that he will be unable to obtain a fair trial.¹⁵¹

In short, Judges Rogers and Tatel identified the ways in which medication could impact the operation of Weston's trial-related rights, as well as his liberty, and concluded that a "searching examination"¹⁵² of these possible impacts is required. Their opinions exemplify the functional view.

147. Although she provides no specific standards for such an inquiry, Judge Rogers refers the district court to Judge Tatel's concurring opinion for guidance on the inquiry. *Id.*

148. *Id.* at 18.

149. "Weston's fair trial rights include rights (1) not to be tried unless he is competent to "consult with counsel, and to assist in preparing his defense"; (2) to testify and "present his own version of events in his own words"; (3) to be present in the courtroom at every stage of the trial; and (4) to present a defense, including an insanity defense." *Id.* at 20 (Tatel, J., concurring) (citations omitted).

150. *Id.* at 20.

151. *Id.* at 21.

152. *Id.* at 19 (Rogers, J., concurring) ("[T]he district court must engage in a searching examination of whether forced medication will impermissibly interfere with Weston's right to a fair trial in light of the serious and complicated issues raised by the effects that such medication may have upon Weston's demeanor at trial and his ability to assist in his own defense."); *id.* at 19 (Tatel, J., concurring) ("I also agree with Judge Rogers' standard of review discussion").

2. A UNIFORM MODEL OF INVOLUNTARY MEDICATION

In 1990, the United States Supreme Court held in *Washington v. Harper*¹⁵³ that involuntary psychotropic medication of a mentally ill prison inmate implicated a significant liberty interest in avoiding unwanted medication,¹⁵⁴ but that because the person being medicated was a prison inmate, the regulations permitting such medication need only be “reasonably related to legitimate penological interests” in order to be constitutional.¹⁵⁵ This substantive limit upon involuntary medication was satisfied if the inmate was dangerous to himself or others and the treatment was in the inmate’s medical interest—no other interests needed to be considered.¹⁵⁶ The Court further held that the constitutionally required procedure, before the state could undertake such medication, was no more elaborate than an opportunity to be present at an adversary hearing, and to present and cross examine witnesses.¹⁵⁷ No formalized procedures, standards or rules of evidence, right to counsel or opportunity for subsequent independent or judicial review were required.¹⁵⁸ The author of the Court’s opinion in *Harper* stressed in *Riggins v. Nevada* that involuntary medication to ensure that an incarcerated person was not dangerous presented a very different problem than did involuntary medication to achieve competence.¹⁵⁹ Nevertheless, several courts have adopted this uniform view of involuntary psychotropic medication, which treats the considerations in these situations as essentially the same.

Since the Supreme Court’s decision in *Riggins*, one federal circuit (the Fourth) has held that a pretrial criminal defendant who has been hospitalized may be involuntarily medicated without any formal hearing procedure whatsoever, as long as the decision is a professional medical judgment.¹⁶⁰ The courts of several states have held that criminal

153. 494 U.S. 210 (1990).

154. *Id.* at 221-22.

155. *Id.* at 224.

156. *Id.* at 221.

157. *Id.* at 235.

158. *Id.* at 236.

159. *Riggins*, 504 U.S. at 140 (Kennedy, J., concurring in judgment) (“This is not a case like *Washington v. Harper*, in which the purpose of the involuntary medication was to ensure that the incarcerated person ceased to be a physical danger to himself or others”) (citation omitted).

160. *Hogan v. Carter*, 85 F.3d 1113, 1114 (4th Cir. 1996) (en banc) (holding physician who ordered emergency psychotropic medication of inmate in prison hospital without hearing or other procedure entitled to qualified immunity from prisoner’s § 1983 suit because no clearly established law that such procedure must occur, and due process requires only professional medical judgment that medication was appropriate). In *Hogan* the court affirmed the continuing vitality of *Charters*, 863 F.2d 302, which predated *Riggins*. *Id.* at 1118. The validity of *Charters* itself is arguably in doubt, based upon the Supreme Court’s decision in *Harper*. See *Hogan*, 85 F.3d at 1119 (Motz, J.,

defendants—even when involuntarily medicated solely to achieve or maintain competence—are entitled to no more protection.¹⁶¹

The principle that both procedural and substantive due process impose only minimal limits to intrusions on liberty when undertaken as part of care and treatment of the mentally ill, has its origin in the *parens patriae* rationale exemplified by the Supreme Court decision in *Youngberg v. Romeo*.¹⁶² In *Youngberg*, the Court found that “[t]he mere fact that Romeo has been committed under proper procedures does not deprive him of all substantive liberty interests under the Fourteenth Amendment.”¹⁶³ However, in determining whether a “substantive right protected by the Due Process Clause has been violated, it is necessary to balance ‘the liberty of the individual’ and ‘the demands of an organized society.’”¹⁶⁴ Romeo’s liberty interest, according to the Court, was “that a professional judgment in fact be exercised” in determining when a legitimate state interest outweighed the rights of “the involuntarily committed to reasonable conditions of safety and freedom from unreasonable restraint.”¹⁶⁵ This methodology for analyzing the right

concurring in judgment); *see also Morgan*, 193 F.3d at 262 (“[T]he determination of whether to forcibly medicate a pretrial detainee such as Morgan rests upon the professional judgment of institutional medical personnel, subject only to judicial review for arbitrariness.”).

161. *See, e.g., Khiem*, 612 A.2d 160; *Donaldson*, 847 P.2d at 634 (involuntary medication is permissible where state establishes by clear and convincing evidence defendant incompetent to “effectively participate in the treatment decision,” treatment is necessary to prevent significant and likely long-term deterioration in condition or to prevent likelihood that patient will cause serious harm to self or others in institution, no less intrusive alternative and patient’s need for treatment overrides any bona fide interest in refusing treatment), *but see id.* at 635-36 (Scott, J. dissenting) (finding that the factors supporting involuntary medication insufficiently proven, and that the state’s true purpose was to restore defendant’s competence to stand trial); *Armstrong*, So. 2d at 692 (involuntary medication of pretrial defendant permissible where state shows it is appropriate and, “considering less intrusive alternatives, essential for the safety of the defendant and others”); *Baker*, 511 N.W.2d 757; *Adams*, 888 P.2d at 1210 (holding that a pretrial defendant may be subject to involuntary medication upon showing medically appropriate and necessary to help defendant become competent and no less intrusive means for achieving competence); *Van Orden*, 647 N.E.2d 641; *Lawrence v. Georgia*, 454 S.E.2d 446 (Ga. 1995).

162. 457 U.S. 307 (1982). In *Youngberg*, a profoundly retarded plaintiff involuntarily committed, brought a civil rights claim under 42 U.S.C. § 1983, claiming rights under the Due Process Clause of the Fourteenth Amendment to safe conditions, freedom from bodily restraints and to training or “habilitation.” The procedure the Court held he was due in making determinations about his treatment was simply that the decision had been a “professional medical judgment.” *Id.* at 321-22; *see also Woodland*, 820 F. Supp. at 1505-06 (explaining how rationale from cases involving right to refuse treatment was imported into involuntary medication context).

163. *Youngberg*, 457 U.S. at 315.

164. *Id.* at 320 (citing *Poe v. Ullman*, 367 U.S. 497 (1961) (Harlan, J., dissenting)).

165. *Id.* at 321. As to whether Romeo had a substantive due process right to a particular level of care, training and freedom from restraints, the Court left this

applicable to a case of involuntary care (here the right to refuse treatment) is based on a model driven by treatment decisions. In Gutheil and Appelbaum's terms, it is a "treatment-driven" rather than a "rights-driven" model.¹⁶⁶

a. Substantive due process requirements under the uniform model

Just before the Supreme Court's decision in *Harper*, the Fourth Circuit held in *United States v. Charters* that the decision to involuntarily medicate an incompetent criminal defendant need only be a "professional judgment"—a non-arbitrary decision made by an appropriate professional—and has since reaffirmed this standard notwithstanding *Harper*. Michael Charters was charged in 1983 with threatening the president.¹⁶⁷ Found incompetent to stand trial and dangerous, he was committed to the custody of the attorney general for the purpose of care and treatment in order to restore competency in 1984.¹⁶⁸ Diagnosed as suffering from degenerative schizophrenia, the government sought to symptomatically treat (but not cure) him with antipsychotic medication.¹⁶⁹ The Court held that substantive due process was not implicated by his involuntary medication, as he had been legally committed, and so his "retained interest in freedom from bodily intrusion must yield to the legitimate incidents of his institutionalization."¹⁷⁰ No consideration was given to the impact of medication on Charters' trial-related rights.¹⁷¹

undecided—so long as he received whatever level of care, training and freedom from restraints professional medical judgment dictated. *Id.* at 324-25.

166. See generally Paul S. Appelbaum, *The Right to Refuse Treatment With Antipsychotic Medications: Retrospect and Prospect*, 145 AM. J. PSYCHIATRY 4 (1988).

167. *Charters*, 863 F.2d at 306.

168. *Id.* at 304.

169. *Id.*

170. *Id.* at 306.

171. The Fourth Circuit has very recently reaffirmed this position in *Charters* by again refusing to consider the effects on a pretrial criminal defendant's constitutional rights of a finding by a prison hospital that he is "dangerous," and thus permitting medication, in *United States v. Morgan*, 193 F.3d 252 (4th Cir. 1999):

The fact remains, however, that the finding that treatment with antipsychotic medication was necessary to render Morgan competent to stand trial was accompanied by a finding that such medication was necessary because he is dangerous to himself and to others at Springfield. Although Morgan provides us with no psychiatric evidence supporting a conclusion that the "dangerousness" finding was made arbitrarily, he essentially requests that we disregard that finding so that we may evaluate the constitutionality of permitting Springfield medical personnel to make the determination of whether to forcibly medicate him solely for the purpose of rendering him competent to stand trial. This we are unwilling to do.

b. Procedural due process requirements under the uniform model

Not only did the *Charters* court fail to examine the substantive limits upon his involuntary medication, but it also concluded that the only procedure required—when the government was acting to care and treat Charters rather than punish him¹⁷²—was a professional medical judgment, which required no hearing whatsoever. That Charters had not been convicted of anything was not significant to the court, and only the dissent appeared to recognize the distinctive aspect of the case presented by the fusion of prosecutor and involuntary medicator in one authority.¹⁷³ The Fourth Circuit has since reaffirmed the validity of the reasoning in *Charters* in the context of emergency medication of a mentally ill prison inmate.¹⁷⁴ It has also held, at least in the context of involuntary medication of a “dangerous” pretrial detainee, that an administrative proceeding before hospital personnel uninvolved in the treatment of the inmate, with twenty-four hours notice and the opportunity to be heard, be represented by a staff member and to request that witnesses be questioned, is a constitutionally adequate procedure.¹⁷⁵ Although no particular burden of proof is identified, the administrative decision is reviewed merely for “arbitrariness.”¹⁷⁶ Other cases suggest that pretrial defendants who have been judicially committed in order to restore competency to stand trial (rather than on an emergency basis) may in fact face medication with even less procedural formality than was present in *Charters*.¹⁷⁷

Id. at 264.

172. 863 F.2d at 312.

173. *Id.* at 315 (Murnaghan, J., dissenting) (“The prospect that the views of a governmental medical official may be inclined to coincide with those of the federal prosecutor on the desirability of the trial’s proceeding and a resulting conviction leading to lengthy incarceration is not remote.”).

174. *Hogan*, 85 F.3d at 1118 (“The Supreme Court presumably believed *Charters*’ “professional medical judgment” standard sufficiently consistent with *Harper*’s due process standard that it did not even remand *Charters* for reconsideration in light of *Harper*, but rather denied *certiorari* in the case less than a week after issuing its opinion in *Harper*.”).

175. *See Morgan*, 193 F.3d at 262.

176. *Id.*

177. *See, e.g., Kulas*, 159 F.3d at 459 (Wallach, J., dissenting) (indicating that the pretrial defendant found not competent to stand trial and committed for evaluation was medicated when his physician “simply marked [his] chart ‘may not refuse medication’ and left”). Of course, this does not include defendants about whom competency to stand trial is not addressed or never raised. Even an attempt to obtain an accurate sense of a defendant’s mental state at the time of the crime—to vindicate their right to effective assistance of counsel—does not ensure that their due process right to proceed only when competent will be protected. *See, e.g., Meade v. Or. State Hosp. Psychiatric Review Bd.*, No. 98-36063, 1999 U.S. App. LEXIS 27383, at *8 (9th Cir. 1999) (holding

3. A FUNCTIONAL MODEL OF INVOLUNTARY MEDICATION

Prior to *Riggins*, the courts of several states had specifically recognized that both Sixth Amendment-based trial rights¹⁷⁸ and due process rights based upon liberty or privacy are implicated by involuntary medication.¹⁷⁹ Trial-related rights were recognized as a basis for relief where a defendant demonstrated that he had been involuntarily medicated,¹⁸⁰ so that his demeanor could not be accurately placed before the fact finder.¹⁸¹ The types of trial-related rights held to be implicated by involuntary medication included the defendant's right to "present his version of the facts,"¹⁸² to be present at trial,¹⁸³ to confront his accusers, to be free to use his mental faculties at trial and to interact effectively with his counsel. A few courts noted the overlap between these sets of rights,¹⁸⁴ at least in cases in which the defendant was claiming both that

defendant denied effective assistance of counsel after he had been removed from medication for forensic examination, determined to have insanity defense, and then different counsel represented him, and stipulated to facts, after which he was found guilty except for insanity and sentenced to twenty years supervision by the state psychiatric security review board, despite his being unable to speak at the hearing and possibly having not been present at the hearing).

178. *See* *State v. Maryott*, 492 P.2d 239, 242 (Wash. Ct. App. 1971) ("The historical abhorrence of any measures which affect a person's mind at the time of trial; the loss of an individual's exclusive control of his mental processes at the time of trial; and the compromising of the adversary process each furnish sufficient reason" to find a due process violation.); *State v. Hayes*, 389 A.2d 1379 (N.H. 1978); *Commonwealth v. Louraine*, 453 N.E.2d 437, 442 (Mass. 1983) (holding that a defendant's right to a fair trial is denied by the deprivation of an opportunity to place his true demeanor before jury, and to present his version of the facts).

179. *Maryott*, 492 P.2d at 241 ("We are here concerned with state action which may infringe on the ability to think and its conflict with due process of law.").

180. *See, e.g., Murphy*, 355 P.2d 323; *State v. Gwaltney*, 468 P.2d 433 (Wash. 1970); *In re Pray*, 336 A.2d 174 (Vt. 1975). Where the defendant knew of his medication and was expressly given an opportunity to present evidence of its effect to the jury and did not, so the continuation of medication could be seen as a strategic decision, no violation of trial-related rights was found. *See State v. Jojola*, 553 P.2d 1296, 1300 (N.M. 1976).

181. *Louraine*, 453 N.E.2d at 442; *Gurney*, 595 N.E.2d at 324 (arguing that the defendant's mental illness prevented him from forming requisite mental state for offense entitled to offer expert testimony concerning antipsychotic medication he was taking at trial to prevent jury from unfairly considering his "controlled behavior at trial" against his claimed psychosis at time of the alleged crime).

182. *Louraine*, 453 N.E.2d at 441.

183. *Allen*, 397 U.S. at 338, *recognized in Maryott*, 492 P.2d 239.

184. *See Maryott*, 492 P.2d at 242 ("On the subsidiary question of whether the state may, over the objection of the defendant, administer drugs which affect his mental and/or physical ability at the time of trial when his mental responsibility to commit the act is at issue, due process of law requires as a minimum a right of a defendant to examine the witnesses against him, to offer testimony, and to be represented by counsel."); *Jojola*, 553 P.2d at 1299-1300 (characterizing "absolute right to be tried" when not medicated and a separate due process issue which arises when the defendant's demeanor is relevant to his

medication had been administered involuntarily and that he had been attempting to make out a defense based upon his mental state at the time of the offense,¹⁸⁵ although at least one then misconstrues the rights as only being impacted if the defendant is offering a mental state defense.¹⁸⁶ This methodology for analyzing the issue is analogous to the “rights-driven” model for analyzing the competing interests Gutheil and Appelbaum have identified.¹⁸⁷

a. Substantive due process requirements under the functional model

Perhaps the most important distinction between the functional and uniform approaches is the substantive due process standard each imposes. The functional view applies a standard of “strict scrutiny”¹⁸⁸ for the burden at issue,¹⁸⁹ and several decisions have suggested that some variant of strict scrutiny is appropriate.¹⁹⁰ Justice Kennedy’s concurrence in *Riggins* described the “extraordinary showing” he would require,¹⁹¹ and while Justice O’Connor’s majority opinion disclaimed that it was adopting a standard of strict scrutiny, the distinction appears fine at

theory of defense). Post-*Riggins* cases have done this as well. *See, e.g.*, *United States v. Brandon*, 158 F.3d 947 (6th Cir. 1998):

[Defendant’s] interests in avoiding forced medication are several and significant. He has a First Amendment interest in avoiding forced medication, which may interfere with his ability to communicate ideas. . . . Further, the issue of forced medication implicates [defendant’s] Fifth Amendment liberty interest in being free from bodily intrusion. . . . Also involved is [defendant’s] Sixth Amendment right to a fair trial.

Id. at 953-54.

185. *See, e.g.*, *Harrison v. State*, 635 So. 2d 894, 905-06 (Miss. 1994) (applying *Riggins* standard that drugs be medically appropriate, essential for safeguarding compelling state interest and no less intrusive alternative, but only when defendant raises an insanity defense). *But see* *State v. Odiaga*, 871 P.2d 801 (Idaho 1994) (recognizing due process violation from involuntary medication of defendant despite jurisdiction’s lack of an insanity defense).

186. *Id.* The rights to interact with counsel, present a defense, testify, and be present can be impaired by involuntary medication even if a mental state defense is not offered, because even if the medication’s effects do not affect a jury’s consideration of the case, they may well impede the defendant’s enforcement of his own rights through its effect on his mental faculties or through side effects.

187. *See* Gutheil & Appelbaum, *supra* note 97.

188. A challenged rule which burdens a fundamental right will survive “strict scrutiny” if it is narrowly tailored to achieve a compelling government interest. *See, e.g.*, *Roe*, 410 U.S. at 154.

189. *See Woodland*, 820 F. Supp. at 1510 (holding it would be error “to allow the State of Utah to forcibly medicate the plaintiff unless the court find’s [sic] the State’s interest in so acting is ‘compelling’” in case of murder defendant found not competent and hospitalized); *see also* *Brandon*, 158 F.3d at 957; *Bee v. Greaves*, 744 F.2d 1387, 1395 (10th Cir. 1984).

190. *See, e.g.*, *Woodland*, 820 F. Supp. at 1510.

191. *Riggins*, 504 U.S. at 139 (Kennedy, J., concurring).

best.¹⁹² The rationale for strict scrutiny is straightforward; the rights at issue are fundamental rights (such as the right to a fair trial¹⁹³), and involuntary medication unquestionably burdens them. The government interest in medicating the defendant must thus be “compelling.”

The fullest exploration of the inquiry that must be undertaken of the interests implicated by involuntary medication was probably made in *Woodland v. Angus*.¹⁹⁴ Eugene Nate Woodland was charged with second degree murder, and was found not competent to stand trial in 1990. Woodland was committed to the Utah State Hospital; there, he was found incompetent to give informed consent to treatment.¹⁹⁵ He was diagnosed as suffering from bipolar disorder, hypomanic state, dementia (suspected to be secondary to alcoholism), and alcohol dependency.¹⁹⁶ The hospital created a policy that permitted involuntary medication based only on a finding that such was in the patient’s medical best interest and in accordance with prevailing standards of medical practice.¹⁹⁷ When it attempted to medicate Woodland pursuant to this policy, he brought a federal civil rights action, claiming that the policy violated his federal constitutional rights to due process.

The court found that this policy violated substantive due process, under *Harper* and *Riggins*.¹⁹⁸ It noted that whatever the Supreme Court’s reluctance to identify strict scrutiny as the standard in *Riggins*, it was clear that medication of at least some pretrial detainees would be unconstitutional, even if no less intrusive means of establishing competency were available.¹⁹⁹ The Court in *Woodland* found support for the “compelling state interest” part of the strict scrutiny standard in Justice Kennedy’s concurrence, and it rejected the State’s assertions that its interests in bringing the case to trial outweighed those of the plaintiff.²⁰⁰

The court examined the respective interests of the plaintiff and the State. As a preliminary matter, the court found that the State had not even demonstrated to a reasonable degree of medical certainty that forcible medication would likely render the plaintiff competent to stand trial.²⁰¹ First, the court considered the effect imposed by forcible medication on the plaintiff’s privacy interests, and found it a “substantial intrusion” on his liberty interests and an “extensive encroachment” of his bodily

192. *Id.* at 136.

193. “The right to a fair trial is a fundamental liberty secured by the Fourteenth Amendment.” *Estelle v. Williams*, 425 U.S. 501, 503-04 (1976).

194. *See* 820 F. Supp. 1497.

195. *Id.* at 1500-01.

196. *See id.* at 1500.

197. *See id.* at 1501.

198. *See id.* at 1510.

199. *See id.*

200. *Id.* at 1509-10.

201. *See id.* at 1511-12.

integrity.²⁰² Second, it considered the community's interest in "fairly and accurately determining plaintiff's guilt or innocence," and found that this interest did not weigh in favor of medication, given the possible impact on the defendant's demeanor from side effects of the medication, and the fact that preventing medication would not result in his release.²⁰³

Finally, the court considered whether the State had shown it could not obtain the adjudication with less-intrusive means.²⁰⁴ It noted the State had offered no evidence that medication would enable it to obtain an adjudication, and in fact its evidence showed that forcible medication was not likely to render the defendant competent to make treatment decisions.²⁰⁵ Thus, the Court found "on the specific facts of this case . . . the State's interest in trying plaintiff for murder is not sufficiently compelling to allow the forcible medication of plaintiff."²⁰⁶

b. Procedural due process requirements under the functional model

The functional model for evaluating the impact of involuntary medication places the burden for demonstrating the appropriateness of involuntary medication upon the government, and typically requires that this burden be discharged through at least clear and convincing evidence.²⁰⁷

II. ADVANCES IN PSYCHOTROPIC MEDICATION

Changes in available psychotropic medications, and in the assessment of the risk of their temporary discontinuation, raise questions concerning the validity of the existing substantive due process jurisprudence. Today, the range of psychotropic drugs available to treat conditions that may render persons not competent to stand trial, as well as the safety and efficacy of these drugs, is significantly greater than it was only two decades ago. This wider range of safer and more effective medications, with significantly reduced side effects, should be factored into the Court's substantive due process jurisprudence. To the extent that many of the concerns that led to the Court's substantive due process jurisprudence concerning involuntary medication in *Washington v. Harper*²⁰⁸ were based upon risks or perceived risks to safety from the use

202. *Id.* at 1513.

203. *Id.*

204. *Id.* at 1514.

205. *Id.*

206. *Id.*

207. *See Brandon*, 158 F.3d at 957; *Bee*, 744 F.2d at 1395.

208. 494 U.S. at 229-30 (describing "serious, even fatal, side effects" of antipsychotic drugs, including "acute dystonia (severe involuntary spasm of upper body, tongue, throat, or eyes," . . . "akathisia (motor restlessness, often characterized by an

of these drugs or from their side effects, these concerns can be minimized because of the increased safety, efficacy, and reduced side effects of newer drugs.²⁰⁹

Despite these advances in the safety of newer medications, two other trends suggest that continued substantive due process analysis of involuntary medication must be more searching and more nuanced. First, more mentally ill persons are being processed in the criminal justice system than in the past; in some jurisdictions, they may comprise a very significant percentage of incarcerated persons.²¹⁰ Thus any effect of increased use of antipsychotic medication is magnified. Second, these novel antipsychotic medications are being used with much greater frequency in the criminal justice system than they were in the past.²¹¹ This greater use means that the legal consequences associated with their effect on the trial-related rights of criminal defendants, identified in *Riggins v. Nevada*, will (or should) become a much more significant concern.

This section traces the genesis of concern over both the physical risk and legal consequences of undertaking and discontinuing psychotropic medication of the criminal defendant, and attempts to approximate the number of criminal defendants who are subject to psychotropic medication and thus could face these legal consequences.

A. *The History of Psychotropic Medication and Competence to Stand Trial*

“Psychoactive” medication can comprise a range of drugs. The various classes of medications that are said to affect mentation (mental activity) are commonly grouped under the category known as “psychotropics.” Psychotropic medications can include sedatives and

inability to sit still),” “neuroleptic malignant syndrome,” and “tardive dyskinesia, perhaps the most discussed side effect of antipsychotic drugs”); see also *Riggins*, 504 U.S. at 134 (quoting *Harper’s* discussion and characterizing interference of antipsychotic drugs with individual’s liberty as “particularly severe”).

209. See Neil S. Kaye & Thomas J. Reed, *Tardive Dyskinesia: Tremors in Law and Medicine*, 27 J. AM. ACAD. PSYCHIATRY & L. 315, 316 (1999) (noting that, in treatment of tardive dyskinesia with clozapine, risperidone, olanzapine, and quetiapine, “recent evidence for increased safety with these newer agents is impressive”).

210. See, e.g., Robert L. Trestman, *Behind Bars: Personality Disorders*, 28 J. AM. ACAD. PSYCHIATRY & L. 232, 232 (2000) (“A current national trend finds more individuals with severe and persistent mental illness revolving through our jails and collecting in our prisons.”).

211. It has even been suggested that the standard of care for a prescribing physician should be the initial use of these novel antipsychotics in treating psychotic disorders. See Kaye & Reed, *supra* note 209, at 331; see also ALLAN TASMAN ET AL., PSYCHIATRY 1583 (1997) (“The newer antipsychotic agents have substantially altered our view of the opportunities for treating psychosis. These drugs are at least as effective as conventional drugs and are associated with different side effect profiles.”).

tranquilizers (used to quiet, calm, or allay excitement, anxiety and agitation, and may be used to induce sedation), hypnotics (to induce sleep), mood stabilizers (to attain mood that does not rapidly fluctuate between extremes), antidepressants (to alleviate depressive symptoms), and antipsychotics (also called neuroleptics).

The antipsychotics highlighted in this review are used for the primary purpose of reversing psychotic symptoms, which can be present in severe mental illness. Persons with psychotic symptoms may hear voices, hold bizarre beliefs (such as the perception that others are out to get them or that forces control their actions or their thoughts), experience disorganized and disjointed thinking and exhibit unusual behaviors. The so-called “negative” symptoms (social isolation, apathy, and decreased communicativeness) may also be present in persons with major mental illnesses, and may be debilitating and difficult to treat.²¹² This Article focuses on the newer antipsychotic or neuroleptic medications—the so-called “novel antipsychotics”—which will likely require the Court to revisit and clarify its involuntary medication jurisprudence.²¹³

1. THE TRADITIONAL ANTIPSYCHOTICS AND THE REDUCED RISKS AND SIDE EFFECTS OF THE NOVEL ANTIPSYCHOTICS

The consequences of pharmacologically creating or maintaining “artificial competence”²¹⁴ have concerned the legal and medical professions for several decades. They involve two basic types of risk considerations: risks associated with undertaking treatment with psychotropic drugs and risks associated with discontinuing such treatment. Undertaking treatment with psychotropic medication may carry with it risks of significant side effects. Risks such as acute dystonia,²¹⁵ akathisia,²¹⁶ neuroleptic malignant syndrome²¹⁷ and tardive

212. TASMAN, *supra* note 211, at 1569-83.

213. The impact that the novel antipsychotics have had and will have on medical practice has also been noted.

The impact of the newer drugs—currently risperidone and clozapine—will also be increased as even newer drugs become available to physicians. A number of these compounds including sertindole, olanzapine, seroquel, and ziprasidone are in the late stages of development and will probably be introduced in the late 1990s. Each of these compounds will be a significant advance when compared with the older drugs. It is likely that the conventional antipsychotic medications will be totally replaced by these newer compounds with some exceptions.

Id. at 1583.

214. Gutheil & Appelbaum, *supra* note 97, at 100-18.

215. A severe involuntary spasm of the upper body, tongue and throat.

216. Motor restlessness, inability to sit still.

217. A potentially fatal condition that can cause cardiac dysfunction.

dyskinesia,²¹⁸ were the features first identified by the Supreme Court in *Harper* as a basis for substantive due process considerations in the involuntary treatment context.²¹⁹ In addition to side effects, treatment with psychotropic drugs carries with it collateral legal risks for the pretrial criminal defendant—because of the treatment’s intended and unintended consequences—and these were the types of risks identified as raising substantive due process considerations in *Riggins*.²²⁰ The severity of these latter risks has in the past been seen as another reason to restrict the use of antipsychotic medication.

Treatment with drugs, which can have the intended or unintended effect of altering the defendant’s behavior, demeanor or speech, can impair both the defendant’s trial-related rights to participate in his case and to present a defense.²²¹ Drugs that calm defendants might enable greater participation with the trial process, but drugs that raise a defendant’s nervousness hinder effective participation in a trial.²²² Calmness that comes with sedation, or drowsiness, hinders a defendant’s participation in his case, as does restlessness. In addition to these very significant effects on a defendant’s participation in his case, medication can actually change the evidence before the jury. If the evidence of the defendant’s mental state at the time of the offense is either his or her testimony, medication alters what may be critical evidence concerning the defendant’s mental state.²²³

Since at least 1971, evaluators have recognized that the evaluation process itself can have an effect upon what it is ostensibly designed to measure: the defendant’s competency to stand trial. Dr. Cecil Mynatt, then-superintendent of Eastern State Psychiatric Hospital in Tennessee, noted the effect of “[a] . . . hospitalization [during an evaluation period] in itself furnish[ing] enough emotional support for some patients to reorganize their psychic apparatus to a degree that superficially resembles competence.”²²⁴

In addition to the stabilizing effect of the hospitalization process, Dr. Mynatt also identified several deleterious legal consequences presented

218. A neurological disorder characterized by involuntary, uncontrollable movements of various muscles, especially around the face. *See Harper*, 494 U.S. at 230.

219. *Harper*, 494 U.S. at 230.

220. *Riggins*, 504 U.S. at 142 (Kennedy, J., concurring) (noting potentially serious side effects of antipsychotic medication identified in *Harper*, and “more relevant” side effects that can “prejudice the accused” “by altering his demeanor in a manner that will prejudice his reactions and presentation in the courtroom” and by “rendering him unable or unwilling to assist counsel.”).

221. *See* Gutheil & Appelbaum, *supra* note 97, at 100-18.

222. *Riggins*, 504 U.S. at 137 (noting expert testimony that Mellaril dosage defendant received could make him “uptight,” and that daily use might cause “drowsiness or confusion”).

223. *Id.* at 143-44 (Kennedy, J., concurring).

224. Cecil F. Mynatt, *Artificial Competence*, 22 HOSP. & COMMUNITY PSYCHIATRY 96, 96 (1971).

by the effect of treatment with the traditional psychotropic medications. These included both direct effects on the decision making abilities of the defendant due to the anxiety-reducing effects of the medications, and indirect effects on the perceptions of decision makers in the legal system, whose decisions affected the rights of the defendant, because they made decisions based upon observation of the defendant in a medicated, rather than an unmedicated state. The direct effects were the result of the potency and efficacy of the medications, which could in turn reduce the defendant's ability to effectively assist counsel in preparing and executing his defense. The indirect effects were consequences of both the potency of the medications and their side effects. The effects of the drug are discounted beyond the recognition of its importance in maintaining the individual's competence. Psychotropic drugs are powerful chemicals; the removal of neurotic or psychotic symptoms can be accompanied by a lessening of normal anxiety, and can permit a "don't care" mental status rather than responses based on self-protection.²²⁵ The influence of the medication on the defendant's range of emotional expression may even damage his case. Other courtroom observers may—through misinterpreting the pharmacological effects—perceive the defendant as blasé and uninterested in the crime and its victims. This drug-induced indifference could conceivably influence judge and jury in their evaluation of guilt and punishment.²²⁶

However, it is important to note that persons with serious psychotic illnesses can present with decreased range of emotional expression, apathy, and decreased communicativeness as a result of the illness itself, as part of the "negative symptoms". In many cases, these symptoms can be improved with the newer medications,²²⁷ thereby dispelling the earlier beliefs that the use of medications only dampened mental status.

While the use of antipsychotic medication has increased significantly since Dr. Mynatt made his observations, the development of newer types of antipsychotic medications may change the force of some of his concerns. As noted, the last decade has seen the development and introduction of new classes of antipsychotic medications that provide an equal, if not greater, efficacy than past agents, and that are being used with greater frequency than in the past. These drugs also lack some of the debilitating side effects of past pharmacological treatments, and the impact of those side effects are less significant when a decision is made to involuntarily medicate. In 1988, a double-blind study compared the effects of treatment of patients with schizophrenia with the novel antipsychotic Clozapine and the traditional antipsychotic medication Chlorpromazine (i.e. Thorazine). The study examined treatment with

225. *Id.*

226. *Id.*

227. J.M. Kane et al., *Clozapine, Negative Symptoms, and Extrapyrimal Side Effects*, 55 J. CLIN. PSYCHIATRY 74 (1994).

Clozapine for patients with schizophrenia who had been refractory (failed to respond to prior treatment) for periods of up to five years to treatment with Chlorpromazine. It demonstrated that thirty percent of the Clozapine-treated patients were categorized as “responders,” compared with only four percent of the chlorpromazine-treated patients so categorized. Significantly, “this improvement included negative as well as positive symptom areas.”²²⁸ These results were highly important. “For the first time in 40 years, since the chlorpromazine-like agents had been introduced into clinical practice, there was a drug with greater efficacy and a completely different side effect profile.”²²⁹

More recently, studies of the “novel antipsychotics” including Risperidone, Olanzapine, Quetiapine, and Ziprasidone, have demonstrated their effectiveness in treating refractory patients as well as in offering decreased side effect profiles, including neurological side effects such as tardive dyskinesia.²³⁰ These medications have also been shown to have specific efficacy in the treatment of violence and aggression, and have some ability to treat negative symptoms, thereby improving ability to communicate and relate to others, that may otherwise be impaired as a result of the illness itself.²³¹ The greater degree of tolerability along with decreased side effects, suggest that their use will lead to improved treatment compliance.²³²

Pinals and Buckley recently reviewed the safety and efficacy of six novel antipsychotic medications, four of which were approved for use in the United States since 1990, one of which was withdrawn from marketing because of certain cardiovascular side effects. They concluded that these medications “offer promise for patients with psychotic disorders including schizophrenia, with decreased risk for debilitating neurological side effects such as tardive dyskinesia.”²³³ As the authors note, “the novel antipsychotic agents, however, are not yet a panacea.”²³⁴

228. John Kane, M.D., et al., *Clozapine for the Treatment-Resistant Schizophrenic: A Double-blind Comparison with Chlorpromazine*, 45 ARCHIVES GEN. PSYCHIATRY 789, 789 (1988).

229. Pinals & Buckley, *supra* note 64, at 9.

230. *Id.*

231. *Id.*

232. David G. Cunningham Owens, *Adverse Effects of Antipsychotic Agents: Do Newer Agents Offer Advantages?*, 51 DRUGS 895 (1996).

233. Pinals & Buckley, *supra* note 64, at 19.

234. *Id.* at 14. All medications, psychotropic or otherwise, have potential side effects. The potential side effects of these newer antipsychotics, while still possibly significant for a criminal defendant, are of a much less pronounced and severe character than those associated with the traditional medications. These reduced side effects, however, present both physiological and mental phenomena that could be quite significant for a criminal defendant either pending or undergoing trial. These include orthostatic hypotension (low blood pressure that occurs when one is standing still or gets up from a recumbent position), tachycardia (an abnormally fast heartbeat), sialorrhea (excessive salivary flow), sedation, elevated temperature, weight gain, agitation, insomnia, headaches, nausea, sedation, constipation, dyspepsia (indigestion), and somnolence. *Id.* at

The mechanism of action for these medications is still not fully known, and they are not available in long-acting forms, although they do seem to allow for a greater range of treatment choices to minimize side effects.²³⁵

Finally, any risks associated with antipsychotic medication must be balanced against the risks of the alternative: no treatment. For the class of patients suffering, for example, from the major mental illness of schizophrenia, antipsychotic medication is an accepted cornerstone of treatment.²³⁶ It is arguable, although not yet clear, that foregoing this treatment can have consequences beyond just foregoing possible benefits. Some data suggest that untreated psychosis may have physiological or developmental effects on the brain.²³⁷ While this “toxic psychosis” hypothesis may not ultimately prove correct, there are undeniable psychological, social and emotional consequences for the person suffering with untreated psychoses.²³⁸ Any decision to forgo a treatment regimen whose safety and efficacy has been established must be measured against these costs.²³⁹

2. RISKS ASSOCIATED WITH THE TEMPORARY DISCONTINUATION OF PSYCHOTROPICS: EARLY CONCERNS AND RE-EVALUATION

To the extent that use of antipsychotic medication still affects the trial process, one solution that has been raised in criminal cases is to discontinue medication in order to return the defendant—at least temporarily—to a state similar to that the defendant had at the time of the offense. The idea, however, that a defendant should be permitted to stop medication that was otherwise effective in treating the defendant’s mental illness for the sole purpose of appearing before the court in his unmedicated state raises a number of significant medical and legal dilemmas. Furthermore, it fails to account for the unpredictable nature of the course of psychotic illness in a given individual. Is it necessary for a jury to see a defendant in an unmedicated state to appreciate what his

8-13. Not all of these side effects were associated with all the medications; most were associated with only a few. *Id.*

235. *Id.* Many of the novel or atypical antipsychotics are currently only available in oral, rather than injectable, formulations. This makes them less desirable for involuntary administration. *See, e.g., Weston*, 2001 U.S. Dist. LEXIS 2486, at *17-18. Newer forms of the medications, however, such as a rapidly dissolving oral gel preparation, may facilitate involuntary administration.

236. *Id.* at 16, 26.

237. Jeffrey A. Lieberman, M.D. & Wayne S. Fenton, M.D., *Delayed Detection of Psychosis: Causes, Consequences, and the Effect on Public Health*, 157 AM. J. PSYCHIATRY 1727, 1727-28 (2000) (outlining hypothesis of potential changes in brain volume related to the duration of untreated psychosis).

238. *Id.* at 1728.

239. *Id.* at 1728-29.

mental status might have been at the time of the alleged event?²⁴⁰ Are we protecting the defendant's rights by allowing him to demonstrate his demeanor at the cost of his competency?²⁴¹ Is it clinically sound to believe that reestablishing the defendant's pattern of medication use or refusal months or years after an event will recreate his mental status or demonstrate to the jury his demeanor at the time of the event?²⁴² Are there any other clinically identifiable states, such as intoxication, that the Court permits a defendant to recreate for trial?²⁴³

The medical concern that discontinuing neuroleptics can cause irreparable harm can be traced to a series of studies described in the work of Dr. Richard Jed Wyatt.²⁴⁴ Wyatt found that, "there is evidence that stable schizophrenic patients whose neuroleptics are discontinued and have relapses may have a difficult time returning to their previous level of function."²⁴⁵ More recent studies, however, suggest that remediation presents fewer difficulties with re-establishing stability than had previously been thought, especially if the period off antipsychotic medication is brief and the patient's safety is closely monitored.²⁴⁶ Although debate continues in the medical literature, subsequent work has found that double-blind, placebo-controlled, neuroleptic remediation of a

240. Jeffrey L. Geller, M.D. & Paul S. Appelbaum, M.D., *Competency to Stand Trial: Neuroleptic Medication and Demeanor in Court*, 36 HOSP. & COMMUNITY PSYCHIATRY 6, 7 (1985).

241. Bruce J. Winick, *Psychotropic Medication and Competency to Stand Trial*, AM. B. FOUND. RES. J. 769, 814 (1977).

242. Geller & Appelbaum, *supra* note 240, at 7. Whether a defendant can voluntarily discontinue medication in order to create a videotaped record of such a condition, and thus create potentially exculpatory evidence, is a question that has been raised. See Order on Defendant's Motion for Order Directing the Bridgewater State Hospital to Withdraw the Defendant's Antipsychotic Medication so that He May Be Observed and Recorded in an Unmedicated State, Commonwealth v. Brown, 1998 Mass. Super. LEXIS 664 (Mass. Super. Ct. Dec. 18, 1998) (No. 96-11156) (refusing to order hospital to remove defendant from medication, noting that defendant was competent to choose to discontinue medication by himself, which could raise issue of forcible medication). This defendant ultimately removed himself from medication, and was videotaped in an unmedicated state. The jury viewed this tape, rejected his insanity defense, and convicted him of murder. Kathleen Burge, *Man Convicted of '96 Murders in S. End.*, BOST. GLOBE, Apr. 25, 2001, at B3, available at 2001 WL 3930653.

243. The general unfamiliarity of lay persons with the symptoms of psychosis, as opposed to the widespread experience of most persons with the symptoms of intoxication, is certainly a basis for distinguishing the two situations, and perhaps for much greater latitude concerning the type and quantity of testimony concerning the symptoms of psychosis.

244. Richard Jed Wyatt, *Neuroleptics and the Natural Course of Schizophrenia*, 17 SCHIZOPHRENIA BULL. 325, 328-41 (1991).

245. *Id.* at 325.

246. Sanjiv Kumra et al., *Including Children and Adolescents with Schizophrenia in Medication-Free Research*, 56 AM. J. PSYCHIATRY 1065, 1067 (1999).

group of chronic schizophrenic patients who had undergone a neuroleptic-free period ranging from 22 to 322 days (with a mean of 62 days) was associated with prompt improvement of psychosis-associated symptoms.²⁴⁷ Symptoms of thought disorder, presence of hallucinations, and delusions responded positively after three days of re-medication.²⁴⁸

However, the course of mental illness is not predictable, and stopping medication does not guarantee a return of symptoms that existed at the time of the act. This is an important fact about the natural course of psychotic illnesses. Some persons who discontinue medication will remain asymptomatic for an unpredictable period. Others may develop symptoms that are different from those that were present at the time of the alleged offense. Thus, the notion of taking defendants off medication to “see what they were like” may not be well founded. Therefore, although a brief unmedicated period may be safe, it may not necessarily have the intended yield for the legal issue at hand.

Much of the available literature regarding taking patients off of medications has been generated in the debate over drug-free and placebo research involving patients with schizophrenia. In a 1996 overview of the controversy, Dr. Paul Appelbaum recommended that any continuation of the practice of controlled drug-free research in schizophrenia should include safeguards necessary to ensure appropriateness of study design, minimization of risk and adequacy of informed consent.²⁴⁹ Pinals and Appelbaum further highlighted that the informed consent of an individual who receives or rejects such medication would and should include an assessment of his competence to make such treatment decisions,²⁵⁰ which is distinct from the defendant’s competence to stand trial.

While the medical research involving drug-free subjects, and drug-free periods in order to re-establish a defendant’s mental state at the time of an offense are undertaken for different reasons, inferences about the medical effects can be drawn from the research literature. The medical concern about allowing a short term withdrawal from neuroleptic medication, to preserve a record for trial of the defendant’s demeanor,

247. David Glovinsky et al., *Early Antipsychotic Response to Resumption of Neuroleptics in Drug-Free Chronic Schizophrenic Patients*, 31 *BIOLOGICAL PSYCHIATRY* 968, 970 (1992).

248. *Id.* at 970; *see also* David Pickar & Debra Pinals, *Drug Free Symptoms in Schizophrenia*, ACNP, San Juan, Dec., 1995 (concluding that with patients drug free a mean of 43 days, “These data do not support the notion that drug free periods result in diminished responsiveness to pharmacotherapy . . .”); David A. Curson et al., *Does Short-Term Placebo Treatment of Chronic Schizophrenia Produce Long-Term Harm?*, 293 *BRIT. MED. J.* 726 (1986); Kumra et al., *supra* note 246.

249. Paul S. Appelbaum, *Drug-Free Research in Schizophrenia: An Overview of the Controversy*, 18 *IRB: A REVIEW OF HUMAN SUBJECTS RESEARCH* 1-5 (1996).

250. Debra A. Pinals & Paul S. Appelbaum, *The History and Current Status of Competence and Informed Consent to Research*, 37 *ISR. J. PSYCHIATRY & RELATED SCI.* 82, 84-85 (2000).

either by videotaping or some other means, may be diminished as long as the time is brief, and the decision to withdraw medication is carefully and competently made. Furthermore, during any drug-free period, the defendant's mental health would need both careful monitoring and emergency planning.

3. SYSTEMIC CHANGES INCREASING THE SIGNIFICANCE OF
PSYCHOTROPIC MEDICATION FOR DETERMINATION OF
COMPETENCE TO STAND TRIAL

Notwithstanding the improvement in the types of antipsychotic medications available, the effect of involuntary psychotropic medication of the criminal defendant will become a more significant problem in the near future than it is today, both in terms of the rate at which it will be sought and the severity of the conflict such actions will produce. Several independent factors combine to increase the rate and severity of the problem of involuntary psychotropic medication of the criminal defendant. First, a very significant number of persons with mental illnesses are coming into contact with the criminal justice system.²⁵¹ The cause of this development is unclear. It may be that changes in the legal regimes and treatment models for the mentally ill have led to more persons with mental illnesses being treated in non-institutionalized, outpatient and community-based settings, and have increased the likelihood of contact with the criminal justice system. It may also be that because these persons have difficulty accessing such treatment in the community, they end up in the criminal justice system because of collateral difficulties.²⁵² Second, greater proportions of persons receiving mental health treatment are receiving pharmacological treatment than in the past.²⁵³ This may be due to changes in the structure of the delivery

251. See discussion *infra* Part II.B.

252. The data for the "criminalization hypothesis," that deinstitutionalized mentally ill persons are now being processed in the criminal justice system, are unclear. See Linda A. Teplin, *The Criminalization Hypothesis: Myth, Misnomer, or Management Strategy*, in *LAW & MENTAL HEALTH: MAJOR DEVELOPMENTS AND RESEARCH NEEDS* (Saleem A. Shah & Bruce D. Sales eds., 1991). Although the causal mechanism and duration of the phenomenon was uncertain, Teplin concluded that the fact of mentally ill persons in the criminal justice in increased numbers was undeniable. *Id.* at 172 ("[W]hile the criminalization hypothesis is not supported as a longitudinal trend, there is ample evidence of criminal processing of the mentally ill as a contemporaneous phenomenon.").

253. "Psychotropic medications are among the most widely prescribed medications in the United States. As a class, they represented 8.8% of the prescription drug market in 1994, and their use has been increasing in recent years." H. A. Pincus et al., *Prescribing Trends in Psychotropic Medications: Primary Care, Psychiatry, and Other Medical Specialties*, 279 *JAMA* 526, 526 (1998). Between 1985 and 1993-94, visits to office-based physicians in which a psychotropic drug was prescribed, ordered, supplied, administered or continued rose from 5.1% to 6.5% of all visits. *Id.* at 528.

systems of mental health services, expanded drug research leading to psychotropic medications with improved safety profiles, and development or changes in prescribing practices of mental health practitioners.²⁵⁴ Third, because of the development of new classes of antipsychotic medications, more persons can tolerate pharmacological treatment with fewer debilitating side effects than in the past.²⁵⁵

The combined effects of these three factors mean that more persons treated with psychotropic medications are in the criminal justice system than have been there in the past, and that the health risks of treatment with these medications may be lower than in the past. While the role of mental health professionals in addressing issues of criminal responsibility is the area of practice that generates the most immediate media response, in terms of prevalence, the question of competency to stand trial is “the most important mental health inquiry pursued in the criminal law system.”²⁵⁶ If it is true that an increased number of mentally ill persons in the criminal justice system are receiving treatment with psychotropic medication, this area should receive increased attention in the criminal process—particularly as it affects a defendant’s competency to stand trial.

B. The Rate of Psychopharmacological Treatment in the Criminal Justice System

How many criminal defendants are treated with psychoactive medication?²⁵⁷ This is a difficult question to answer with any specificity,

254. The effect on prescription patterns of the change to managed care has been summarized this way.

Other factors that may be affecting the pattern of psychotropic drug use are changes in the structure of health care delivery and health care reimbursement. In many managed care organizations, the incentives of a capitated system would encourage primary care physicians to maintain responsibility for their patients with mental disorders, treat them efficiently with medications, and not refer them to speciality care.

. . . .

For the past 10 years there has been a dramatic change in the patterns of use of psychotropic medications in outpatient medical practice. Most significant have been the changes in psychiatric practice, especially the greatly expanded use of antidepressant and other medications. These changes reflect the availability of new agents, the expanded, formally approved uses of marketed medications, and the growth and application of the research literature in psychiatry supporting unlabeled uses of medications. It is also likely that changes in reimbursement have affected the patterns of prescribing, not only in psychiatry but also in relationship to other specialty groups.

Id. at 530-31 (internal citations omitted).

255. See TAsMAN, *supra* note 211; Pinals & Buckley, *supra* note 64.

256. ALAN A. STONE, MENTAL HEALTH AND THE LAW: A SYSTEM IN TRANSITION 76-176 (1975); Alan A. Stone, *Psychiatry and the Law*, in HARVARD GUIDE TO MODERN PSYCHIATRY (A.M. Nicholi ed., 1978).

257. Winick, in 1993, concluded that “[p]sychotropic medication is the leading form of treatment administered for the various conditions that render defendants

but some statistics about comparative rates of severe mental illness among the general public and among incarcerated persons, and concerning the use of psychotropic medication in the population at large, suggest some answers.

It has been often observed that the rate of mental illness in correctional populations is higher than that in the general population.²⁵⁸ A 1996 biennial statistical compilation of mental health services and delivery systems in the United States, for example, reports 2.8% of the population as having a “severe and persistent mental illness” and 5.4% of the population as having a “serious mental illness.”²⁵⁹ Based on the definitions for these terms, 2.8% of the population either: (1) exhibited a prevalence of symptoms of a nonaffective psychosis or mania within the past year; (2) would have but for medication or professional treatment; or (3) had been hospitalized or treated with major psychotropic medications.²⁶⁰

By comparison, a Justice Department profile of jail inmates in the United States in 1996 found that approximately ten percent of male

incompetent to stand trial.” Bruce J. Winick, *Psychotropic Medication in the Criminal Trial Process: The Constitutional and Therapeutic Implications of Riggins v. Nevada*, 10 N.Y.L. SCH. J. HUM. RTS. 637, 653 (1993).

258. See Emil R. Pinta, *The Prevalence of Serious Mental Disorders Among U.S. Prisoners*, 1 CORRECTIONAL MENTAL HEALTH REP. 33 (1999); see also Teplin, *supra* note 252, at 164 (“For virtually all mental disorders assessed by the DIS [Diagnostic Interview Schedule], the rates in the jail sample were significantly higher than those estimated in the general population.”).

259. CONGRESSIONAL RESEARCH SERVICE, U.S. MENTAL HEALTH 1996, at fig. 5.1 (Rept. SMA 96-3098). “Serious Mental Illness” means a person has “at least one 12-month DSM disorder other than substance use disorders, and to . . . [has] serious impairment.” One criterion for a “serious impairment” was having a “Severe and Persistent Mental Illness” (i.e., all persons with a serious and persistent mental illness by definition also had a serious mental illness). “Serious and Persistent Mental Illness” was defined as follows:

The first criterion was that the respondent had severe mental illness . . . They defined severe mental illness in terms of the conjunction of diagnosis, disability, and duration. Included were schizophrenia, schizoaffective disorder, manic depressive disorder, autism, and severe forms of major depression, panic disorder, and obsessive compulsive disorder. In the current report, this definition includes the following: (i) 12-month prevalence of nonaffective psychosis or mania; (ii) Lifetime prevalence of nonaffective psychosis or mania accompanied by evidence that the respondent would have been symptomatic if it were not for treatment (defined by either use of medication or any professional treatment in the past 12 months); (iii) 12-month prevalence of either major depression or panic disorder with evidence of severity indicated either by hospitalization or use of major psychotropic medications. In order to discriminate between severe and serious mental illness in this article, severe mental illness will be referred to as “severe and persistent mental illness” (SPMI) while serious mental illness will be referred to as SMI.

Id. at ch. 5.

260. *Id.*

inmates and fifteen percent of female inmates had been admitted to a mental health facility and stayed at least overnight.²⁶¹ After incarceration, jail inmates receive mental health services at a much higher rate than the general population, and the overwhelming majority of those who receive mental health treatment receive psychoactive medication. A 1996 Justice Department profile of jail inmates suggests eighty percent or more of those receiving mental health services in jail receive medication.²⁶²

A 1999 meta-study by Pinta, which identified eight previous studies of the prevalence of mental disorders in prisons in different American jurisdictions that had sufficiently sound methodological criteria, distinguished between “narrow” and “broad” definitions of serious mental disorders.²⁶³ Narrow definitions consisted of DSM-IV²⁶⁴ diagnoses of schizophrenia and other psychotic disorders, major depressive disorder, and bipolar disorder. Broad definitions included other DSM-IV diagnoses manifested by impairment in daily life activities of substantial degree and duration.²⁶⁵ Estimates of both current and lifetime rates for the narrow definitions of serious mental disorders for prisoners ranged from 7.6% to 36.5%, with an average for the studies of about 17.6%.²⁶⁶ Estimates of current and lifetime rates for the narrow definition of serious mental disorders for female prisoners were roughly twice these averages. Although these were studies of prison inmates, rather than jail detainees, assuming that the narrow definition of serious mental disorder is an appropriate proxy for persons potentially subject to antipsychotic medication, and that disorder rates among detainees are at least as high as those among prison inmates, this suggests that roughly one in six detainees is a candidate for psychotropic medication.

Other recent data concerning mental health treatment of prison and jail inmates and probationers suggests that the disproportionate representation of the mentally ill in the criminal justice system continues, and that treatment with psychoactive drugs is the predominant therapeutic regimen. Combining self-reported data from a 1995 study of probationers, a 1996 survey of jail inmates and a 1997 survey of state and

261. CAROLINE WOLF HARLOW, U.S. DEP'T OF JUSTICE, PROFILE OF JAIL INMATES 1996, at 12 (Bureau of Justice Statistics Special Rep., 1998). The study does not reflect the period in which these hospitalizations occurred (e.g., whether they were in the past year, or were lifetime admissions).

262. *Id.* (“After their admission to jail, 10% of male inmates and 20% of females had received mental health services. An estimated 8% of males and 17% of females had taken medication for a mental or emotional problem; 4% of men and 8% of women had been counseled by a professional.”).

263. Pinta, *supra* note 258, at 45 (examining eight studies conducted between 1983 and 1997).

264. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 1994).

265. *Id.* at 34 (conditions *not* included were substance abuse disorders, paraphilias, and antisocial personality disorder).

266. Pinta, *supra* note 258 at 44.

federal prison inmates, a 1999 Justice Department study concluded that roughly 16% of both state prison inmates and those in local jails (i.e., 16.2% of state prison inmates and 16.3% of jail inmates) qualified as being mentally ill, based upon either self-reporting or reporting an overnight admission to a mental hospital.²⁶⁷ These percentages suggest roughly 283,800 mentally ill persons nationwide in 1998 were in the nation's prisons or jails, with roughly two-thirds of these in state prisons and the other third in local jails.²⁶⁸ Federal prisons accounted for about 7,900 mentally ill persons, with about 547,800 mentally ill persons on probation.²⁶⁹ Among the population most likely to comprise pretrial detainees (i.e., local jails), forty-one percent of those identified as mentally ill had received some form of mental health services since admission, and thirty-four percent of mentally ill jail inmates had been given medication.²⁷⁰ This suggests that in local jails, roughly one in twenty detainees has received medication for a mental condition.²⁷¹

III. AN AUTONOMY-BASED, FUNCTIONAL THEORY OF INVOLUNTARY MEDICATION

A. *The Constitutional Principle of Autonomy Implicated by Involuntary Medication of the Criminal Defendant to Establish Competence to Stand Trial*

The issue of involuntary medication of criminal defendants goes to the heart of several important legal principles involving individual liberty, criminal responsibility and the authority of the state. Our legal system is premised upon a principle of autonomy for individuals, particularly in making decisions which principally affect their own lives.²⁷² Decisions regarding the administration of medical and mental health treatment are typical examples of such decisions. Adults are presumed competent to make decisions about their own medical treatment—and this authority over one's treatment decisions is considered an important area of autonomy.

There are two basic justifications upon which this autonomy can be limited: *parens patriae* and police power. Autonomy can be limited to

267. DITTON, *supra* note 35, at 3.

268. *Id.*

269. *Id.*

270. *Id.* at 9.

271. This is simply 34.1% (prescribed medication for jail detainees identified as mentally ill) of 16.3% (percentage of jail inmates identified as mentally ill), or 5.56%. *Id.* at 3, 9 (tbls. 2, 14).

272. The concept of autonomy protection here is based upon Winick's analysis of three bases for substantive due process limitations on involuntary mental health treatment: bodily integrity, mental privacy, and privacy-autonomy. See BRUCE J. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT 201 (1997).

protect individuals who are incapable of protecting themselves, and to protect others from an individual's exercise of autonomy that threatens them. Both of these justifications have found their way into analysis of involuntary medication, but neither satisfactorily supports involuntary medication in a criminal case when it is undertaken in order to establish competence to stand trial, because neither recognizes the full range of consequences of involuntary medication. Involuntary treatment of someone incapable of protecting themselves presumes that the end is therapeutic—which is simply not the case when the primary consequence of treatment and eventual restoration or establishment of competence to stand trial is the criminal prosecution of the person treated.²⁷³ Involuntary treatment of someone whose untreated condition renders that person dangerous presumes that the treatment will reduce or eliminate that individual's dangerousness—which may be the case in the short run but is rarely the case in the long run, where the dominant factor limiting their dangerousness to members of the public is the criminal prosecution and consequent legal restriction (including possibly incarceration or long-term commitment if found not guilty by reason of insanity) of the individual to be treated.²⁷⁴ When a criminal defendant faces involuntary medication to render him competent to stand trial, it defies reality to describe the process primarily as one solely to make the defendant well or to make others safe. Either result may occur, but these are distinct from the ultimate legal consequence of enabling the criminal prosecution.

A person's physical integrity,²⁷⁵ as well as mental integrity²⁷⁶ have long been constitutionally protected. However, a constitutional

273. This is not to say that maintaining a mentally ill person in an untreated condition is therapeutic either; it clearly is not. There are cases of persons remaining for years in a state of potential competence, rejecting medication because of its legal consequences, and thereby foregoing medical benefit. See, e.g., Anne E. Kornblut, *Recovery Leads to Courtroom*, BOSTON GLOBE, July 9, 1998, at A1 (describing a murder defendant who spent fifteen years in state institutions refusing medications before she was competent to stand trial, which ultimately came as a product of "comprehensive treatment and therapy, not drugs alone").

274. Unquestionably, even an incarcerated, mentally ill person can pose a threat to inmates and staff in an institution. Medically appropriate involuntary medication in this circumstance can proceed as an incident to the maintenance of institutional security under *Washington v. Harper*. *Id.*

275. Although not a constitutional decision, *Union Pacific Railway Co. v. Botsford*, 141 U.S. 250 (1891), recognizes the significance of such an interest in protecting bodily integrity (here of personal injury plaintiffs who sought to avoid surgical examination to determine the extent of their injuries). Constitutional bases for the protection of one's bodily integrity include the fourth amendment, *Schmerber v. California*, 384 U.S. 757, 771 (1966) (blood draw from unconscious driver suspected of driving under the influence constitutional because routine and safe), *Winston v. Lee*, 470 U.S. 753, 761, 765-66 (1985) (surgery to remove bullet from defendant's body violates fourth amendment because of medical risks), and due process, *Rochin v. California*, 342 U.S. 165, 209 (1942) (involuntary stomach pumping of defendant to obtain evidence shocks the conscience). See WINICK, *supra* note 272, at 201-09.

framework for involuntary medication of a criminal defendant for the purpose of establishing competence to stand trial must recognize that autonomy is implicated in a fundamentally different way than it would be in an invasion of one's bodily or mental integrity. The involuntary medication of a defendant to establish competence to stand trial, while both a physical and a mental invasion, is also an invasion that poses a fundamental risk to a defendant's legal autonomy.²⁷⁷

B. Competence to Make Treatment Decisions versus Competence to Stand Trial

While the risk of involuntary medication of the criminal defendant is to the defendant's legal autonomy, the involuntariness of the medication undeniably involves a restriction of one's physical and mental autonomy as well. This restriction arises anytime involuntary treatment is undertaken (regardless of whether the person being treated is a criminal defendant) and the medical, legal and ethical concept of competence to make treatment decisions addresses this issue. An individual who lacks competence to make decisions concerning her own treatment may nevertheless be treated, at the government's behest if necessary, under a *parens patriae* rationale. The procedures for overriding this autonomy vary across jurisdictions, from a treatment-driven model to a rights-driven model. Generally, some appropriate process ensures that medication is medically appropriate; some jurisdictions require inquiry to ensure that the individual's own previous expressions concerning treatment, religious preferences, family interests, prognosis with and without treatment, and other considerations are taken into account prior to imposing treatment. A criminal defendant who faces involuntary medication may or may not be competent to make treatment decisions, but this must be addressed independently—before competence to stand trial is addressed—otherwise autonomy cannot genuinely be protected.²⁷⁸

Any effective framework for analysis of involuntary medication thus must distinguish the question of competence to make treatment decisions

276. The constitutional right to liberty in one's speech is of course protected by the first amendment. See, e.g., *Stanley v. Georgia*, 394 U.S. 557 (1969) (protecting possession of pornography in one's home); WINICK, *supra* note 272, at 210-12.

277. Winick describes this interest, implicated by involuntary medication, as privacy-autonomy, for "Constitutional Protections for Personal Choices in Matters Vitrally Affecting the Individual." See *generally id.* See *also id.* at 212. The criminal process would seem to qualify for this description.

278. Winick, in this regard, has noted:

[T]he state's police power interest in restoring these defendants to trial capacity may justify continued treatment with such drugs even over the defendant's objection, but the separate *parens patriae* power should not suffice to justify such treatment absent an additional determination that the defendant is then incompetent to participate in treatment decision making.

WINICK, *supra* note 272, at 293-94.

(including medication), from the question of competence to stand trial. The ultimate questions of competence to stand trial and competence to make treatment decisions are legal ones. The question of competence to make treatment decisions must be addressed as a preliminary treatment matter in order to maintain the legitimacy of the treatment imperative. Otherwise, the process of involuntary medication loses any claim to having a therapeutic basis and becomes simply a mechanism for facilitating the criminal process—with its inherent risk of the derogation of autonomy.²⁷⁹

Unfortunately, the framework in which competency assessments are made—the adversarial process of a criminal case—is inadequate to fully protect a defendant's interests. The defendant's counsel, charged with protecting her legal interest, cannot also protect the defendant's medical interest. A defendant able to make her own decisions about treatment, of course, can protect her own medical interests—and the exercise of her own autonomy—but very often the defendant whose competence to stand trial without medication is at issue is not competent to make treatment decisions. Neither the defense counsel nor the prosecutor is ethically able to protect the defendant's autonomy to make decisions about medication. This inquiry involves considerations of the defendant's medical interests, medical and mental health prognoses with and without medication, alternative therapies, and the defendant's previously expressed preferences. Whether conducted under some sort of substituted judgment analysis, or best-interest analysis, such an inquiry may well require the appointment of a guardian.²⁸⁰

The inquiry must examine whether the defendant possesses the decisional capacities required to meaningfully exercise autonomy in treatment. These capacities have been identified as the ability to communicate a choice, to understand relevant information, to appreciate the situation and its likely consequences, and to manipulate information rationally.²⁸¹ These questions may be related to—but are not necessarily the same as—those undertaken in the competence-to-stand-trial inquiry. When these two questions are conflated, however, it is virtually impossible to ensure that the autonomy of the defendant—as a person with both medical and legal interests—is protected.

279. The failure to distinguish the question of competence to make treatment decisions and competence to stand trial can result in several analytic problems.

280. In *Weston*, for example, counsel sought the appointment of a guardian, although the court concluded that it lacked the statutory authority to appoint one. *Weston*, 2001 U.S. Dist. LEXIS 2486, at *8 n.7. The Court did, however, appoint an independent expert, pursuant to Federal Rule of Evidence 706, to provide an opinion concerning whether it was in defendant's medical interests to involuntarily administer antipsychotic medication. *Id.* at *9.

281. See generally Paul S. Applebaum & Thomas Grisso, *Special Article: Assessing Patients' Capacities to Consent to Treatment*, 319 *NEW ENG. J. MED.* 1635 (1988).

C. Dangerousness as a Justification for Involuntary Medication

In addition to the confusion that arises from the failure to distinguish between competence to stand trial and competence to make treatment decisions, there is a risk of confusion from the failure to distinguish another basis for the restriction of autonomy: dangerousness. The autonomy principle can be inapplicable, as noted above, when an individual is incapable of exercising autonomy (i.e., incapable of making treatment decisions), or it can be trumped when a particular exercise of autonomy would invade or compromise the autonomy of others. For example, an incarcerated person who, through the exercise of his autonomy poses a serious risk to others (say, by forgoing mental health treatment), can lose his autonomy to make treatment decisions. But the use of dangerousness as a basis to involuntarily medicate a pre-trial criminal defendant poses a very serious risk—because of the incidental effects of such a decision on the defendant’s trial-related rights.

The severity of these restrictions upon autonomy demand that the particular restriction of a criminal conviction be accompanied not only by significant substantive limitations upon its exercise (i.e., there are some inherently private practices which cannot be criminalized²⁸²) but also by significant procedural requirements before the limitation of autonomy can occur, such as notice, presence, counsel, jury trial, cross examination, confrontation, and the presentation of evidence. It is especially important that any effort to involuntarily medicate a pretrial criminal defendant on the basis of dangerousness be done with the full range of procedural protections.

Finally, the fact that dangerousness has always been a basis to involuntarily treat someone complicates the analysis of involuntary medication of the criminal defendant in two ways. First, a determination of dangerousness must be made; this type of risk assessment is extremely difficult given the competing facts that the individual is alleged to have committed a crime (perhaps a very violent crime), while at the same time is often in a controlled environment (where the individual may be being evaluated).²⁸³ The underlying paradigms for the Court’s involuntary

282. See, e.g., *Griswold v. Connecticut*, 381 U.S. 479 (1965) (contraception); *Stanley v. Georgia*, 394 U.S. 557 (1969) (possession of pornography); *Loving v. Virginia*, 388 U.S. 1 (1967) (marriage).

283. See, e.g., *United States v. Morgan*, 193 F.3d 252 (4th Cir. 1999). In *Morgan*, a pretrial criminal defendant was presumed to be “dangerous” *based upon the charges against him*, which had yet to be adjudicated, and upon his anger at the prison hospital’s attempt to involuntarily medicate him. The warden of the prison hospital, who denied the defendant’s appeal of the hospital’s decision to involuntarily medicate him, explained “‘as a preventative measure, we must assume that you pose a potential risk to staff,’ a conclusion that he supported by referring to the violent nature of

medication jurisprudence, *parens patriae* and institutional security, both incline one toward medication of a mentally ill defendant—because medication would provide treatment for a person who is believed to have committed such a dangerous act as a product of his mental illness, and because medication of a potentially dangerous person would likely increase institutional safety.

The second difficulty inherent in the dangerousness determination arises from the fact that it is often made in an adversarial context. Recognizing the defendant's rights with respect to competency and his trial-related rights under these circumstances becomes even more problematic.²⁸⁴ If a criminal defendant is found to be dangerous, and could always be treated on the basis of controlling his dangerousness, then no consideration would ever be given to the degree to which treatment would restore competency or impair the defendant's trial-related rights.²⁸⁵ It is these two considerations, rather than dangerousness, which affect the autonomy principle; to permit dangerousness to trump them would mean that autonomy simply would not be protected.

There are emergency situations, when a defendant loses control during a court proceeding, or while detained, which raise the dangerousness consideration and require emergency treatment. But these emergency situations are exactly that: emergencies, which demand prompt response, but are temporary. If they reflect a long-term or chronic condition, then the dangerousness criterion cannot be the final arbiter of medication (or it cannot be used for its incidental effect of rendering the defendant competent to stand trial). Dangerousness, in short, must be a subsidiary consideration in the medication decision if the defendant is going to face a further possible deprivation of autonomy through prosecution.

D. The Conflict between Autonomy and the Government's Interest in Trial

Involuntary medication to establish competence presents a basic conflict between the defendant's autonomy and the interests of the state in effecting a trial. Autonomy is among the most highly prized interests of

the pending charges against Morgan and to Morgan's 'anger and animosity' toward those who proposed that he be treated with antipsychotic medication." *Id.* at 258.

284. PERLIN, *supra* note 120, at 137 (noting that use of *parens patriae* rationale for treatment of detainees inappropriate because "it strains credulity that the same paternalistic impulses motivate federal correctional institutional officials in their dealing with pretrial detainees" as motivate parents concerned with the best interest of their children).

285. *See, e.g., Morgan*, 193 F.3d at 264 ("We realize that forcibly medicating a pretrial detainee on the basis that such treatment is necessary because he is dangerous to himself or others in the institutional setting might have the incidental effect of rendering him competent to stand trial.").

our legal system. Even as the procedural requirements which are prerequisites to the restriction of autonomy are being satisfied, autonomy itself—of the person whose autonomy may ultimately be restricted—must be preserved. Certain critical decisions in the trial process (particularly pleading guilty, representing oneself, and testifying) must be made by the individual whose autonomy is at stake. While the inability to exercise autonomy can be a basis for restricting it through commitment, it is a fundamental substantive violation to put a defendant at risk of losing autonomy through the criminal process, when that defendant is incapable of exercising it.²⁸⁶ There are procedural obligations for all parties to a criminal proceeding to raise and examine the issue of the defendant's ability to exercise autonomy should it ever be in question during the proceedings.²⁸⁷

There are substantive limits on this ability to compromise or restrict autonomy. For instance, a person cannot be found incompetent to make treatment decisions because he rationally makes unwise choices, and he cannot be committed simply because he is disagreeable. Similarly, there are procedural requirements which must be satisfied before such restrictions on autonomy can be undertaken. For example, a hearing must be held, evidence must be taken, and an institutional panel must undertake some process consistent with the exercise of professional judgment.²⁸⁸ The substantive limits protect a sphere of autonomy we believe is fundamental, while the procedural limits ensure legitimacy and accuracy of the process.

Involuntary treatment, by definition, presents a fundamental derogation or compromise of autonomy. But some forms of treatment, including psychotropic medication, may themselves increase or return autonomy to the individual. If involuntary treatment is thus undertaken upon one who is incapable of exercising autonomy, or whose exercise of it threatens others, and the treatment would return or restore autonomy by enabling rational decision making and behavior, then it may be justified—

286. *Dusky v. United States*, 362 U.S. 402, 402 (1960).

287. *See Drope v. Missouri*, 420 U.S. 162, 181 (1975) (“Even when a defendant is competent at the commencement of his trial, a trial court must always be alert to circumstances suggesting a change that would render the accused unable to meet the standards of competence to stand trial.”); *see also* *Commonwealth v. Hill*, 375 N.E.2d 1168, 1175 (Mass. 1978).

288. *See, e.g., Mills v. Rogers*, 457 U.S. 291 (1982). This case explains that the involuntary psychotropic medication of a committed person involves both substantive and procedural aspects, where the substantive issue:

involves a definition of that protected constitutional [liberty] interest [in avoiding unwanted medication], as well as identification of the conditions under which competing state interests might outweigh it The procedural issue concerns the minimum procedures required by the Constitution for determining that the individual's liberty interest actually is outweighed in a particular instance.

Id. (citations omitted).

as it may be when an individual has been committed.²⁸⁹ Indeed, the effect of involuntary treatment may be to enable a criminal defendant to exercise autonomy more effectively—by rendering her competent to stand trial and capable of making decisions.²⁹⁰ But if the purpose of restoring autonomy is to enable the procedural requirements (i.e., a trial) for the *deprivation of autonomy* to be satisfied, the justification for the practice must look beyond the autonomy principle.

One cannot assume, for example, that a deprivation of autonomy will automatically ensue with involuntary medication. A person who is rendered competent to stand trial may in fact be more able to exercise his autonomy, and perhaps provide for a favorable disposition of his own case. Herein lies the tension between the goals of the treating clinician and the lawyer. The treating clinician's efforts toward the goal of establishing or maximizing an individual's functional autonomy and mental health may or may not advance the lawyer's goal of obtaining the best legal outcome for the client. Beyond this rationale for restoring autonomy through medication, the justification must be found in the very significant importance of the government interests at stake.

Despite these distinct notions, it is the conflict between the theoretical goal of restoring autonomy through medicating a defendant to competence and the practical consequences of restricting it through the result of a criminal proceeding which the Supreme Court has sidestepped.²⁹¹ The Court's focus on the process that is due a defendant before the fundamental right can be burdened could suggest that burdening the right—in the ultimate case of a defendant who is not imminently dangerous—is constitutional. But the Court expressly refrained from deciding the question, and concluded that the fundamental rights implicated by involuntary psychotropic medication of a criminal defendant could only be constitutionally burdened upon a very high

289. See *Mills*, 457 U.S. at 296 (noting State's dual arguments, for overriding liberty interest of committed persons in avoiding involuntary psychotropic medication, of police power interest in maintaining institutional order and preventing violence, and a "parent patriae interest in alleviating sufferings of mental illness and providing effective treatment").

290. This may well be the case in *Weston*, for example:

Successful treatment with antipsychotic medication will probably decrease Weston's delusional thinking and increase his attention and ability to concentrate . . . Medication, therefore, has the potential of greatly enhancing Weston's ability to communicate meaningfully with his attorneys. Medication should also enhance Weston's ability to understand and follow the testimony at trial.

Weston, 2001 U.S. Dist. LEXIS 2486, at *50-51.

291. Compare *Riggins*, 504 U.S. at 136 ("The question whether a competent criminal defendant may refuse antipsychotic medication if cessation of medication would render him incompetent at trial is not before us."), with *Riggins*, 504 U.S. at 145 (Kennedy, J., concurring) ("If the State cannot render the defendant competent without involuntary medication, then it must resort to civil commitment, if appropriate, unless the defendant becomes competent through other means.").

showing—while at the same time refusing to explain precisely what the necessary showing was.²⁹² This jurisprudential uncertainty is untenable: the Court must frankly acknowledge that a compelling government interest must be shown in undertaking involuntary medication, and that in certain cases establishing competence to stand trial—alone—may constitute such an interest. The effort to establish bright line rules as to which cases demonstrate this compelling interest is unlikely to be productive—and no meaningful set of bright line rules should be based on the unique procedural considerations of capital cases.²⁹³

IV. RECOMMENDATIONS FOR A LEGAL STANDARD FOR INVOLUNTARY MEDICATION

A. *Core Principles*

The conflict between the uniform and functional views of the interests implicated by involuntary psychotropic medication of the criminal defendant can be resolved largely through reference to a few basic principles often lost in the debate. The Supreme Court would do well to articulate these principles in any analysis of the problem.²⁹⁴ These principles can be distilled as follows:

1. COMPETENCE TO CONSENT TO TREATMENT IS A FUNCTIONAL ABILITY DISTINCT FROM COMPETENCE TO STAND TRIAL, THAT MUST BE EXAMINED SEPARATELY BEFORE INVOLUNTARY MEDICATION TO ESTABLISH COMPETENCE TO STAND TRIAL IS CONSIDERED, IN ORDER TO PROTECT A DEFENDANT'S AUTONOMY.

All persons are presumed competent to stand trial and competent to make treatment decisions.²⁹⁵ Once an issue concerning a defendant's competence is raised, the competence determination is made by the court.²⁹⁶ Unlike competence to stand trial, competence to consent to

292. *See supra* notes 40-42.

293. That *Riggins* and *Weston* are potentially capital cases is hardly an accident. Where the defendant's interests in preserving autonomy are as extreme as the capital context, and the risks to autonomy in the most basic sense as profound, it is perhaps inevitable that the calculus of interests always weighs in favor of anything that preserves autonomy at any cost. These, however, are not the great run of cases in which defendants face medication to establish competence to stand trial.

294. We have represented these principles in a flowchart. *See infra* Appendix.

295. 40 AM. JUR. *Proof of Facts* 171 § 6 (1984) (“[A hearing is] required only when evidence from any source, including the trial judge’s own doubts . . . raises a ‘bona fide doubt’ as to [the] defendant’s competency.”). The presumption of competence is constitutional. *Medina v. California*, 505 U.S. 1244 (1992). *See also* MELTON ET AL., *supra* note 66, § 11.03(a)(2), at 347.

296. SAMUEL JAN BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 694 (1985).

treatment is generally brought to the attention of the court only after there has been a clinical examination or intervention. Mental health professionals involved in such an examination inquire as to various aspects of a person's decision making capacities.²⁹⁷ Competence to stand trial, which also may be evaluated clinically, is raised in the context of criminal proceedings, typically by the defendant's counsel or the court.²⁹⁸ The parameters of capacities required for competence to stand trial have been well-established by the Supreme Court.²⁹⁹ The examination of competence to stand trial is said to protect, among other things, the legitimacy of the trial process and the basic autonomy of the defendant.³⁰⁰ Involuntary medication to achieve competence to stand trial cannot be evaluated in a way that provides maximum protection for autonomy without first examining a defendant's competence to make treatment decisions. Otherwise, the treating mental health professionals simply become adjuncts to the trial process.

When psychotropic medication has been found medically appropriate as a means of restoring or establishing a defendant's competence to stand trial, the defendant's autonomy can be easily compromised unless a preliminary determination of his competence to make treatment decisions is undertaken. Ignoring this preliminary question means that medication will proceed upon a premise that is unsound as a matter of both medical and legal ethics. Neither the autonomy of the patient, a primary goal of mental health treatment, nor the autonomy of the defendant, a basic requisite for the trial process, can be established without first ensuring that a defendant who is medicated as part of the competence to stand trial process is first competent to make decisions about his own treatment.

There is a fairly well-established body of law governing the competence to make treatment decisions. The Court has recognized the right to refuse treatment, which is invoked when a determination must be made about the appropriateness of involuntarily treating a person who is not competent to decide about her own treatment.³⁰¹ When a defendant is determined to be incompetent to make treatment decisions, a

297. These include the ability to express a sustained choice about treatment, to understand information about the risks and benefits related to treatment options, to appreciate their clinical situation, and to rationally manipulate the information presented to them. See generally, Applebaum & Grisso, *supra* note 281, at 1635.

298. See, e.g., *Dusky*, 362 U.S. 402; *Pate*, 383 U.S. 375.

299. See BRAKEL ET AL., *supra* note 296, at 694.

300. *Id.*

301. See *Harper*, 494 U.S. 210; *Mills v. Rogers*, 457 U.S. 291 (1982); *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977). But see *Woodland*, 820 F. Supp. 1497. One commentator has suggested that the apparent greater sensitivity to substantive due process rights the Court has recently shown in the competency to stand trial context should translate into greater sensitivity in the civil right to refuse treatment context. See William M. Brooks, *Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs*, 31 IND. L. REV. 937 (1998).

determination should be made if the medication is in the defendant's medical interests, and a third-party decision maker should be assigned who can act as the defendant's guardian.³⁰² Like a defendant who is competent to make treatment decisions, a guardian would inevitably need to consider all the issues relevant to the risks and benefits of the proposed medications, including the impact on the defendant's trial-related rights. When the guardian seeks or agrees to medication, that medication may be allowed over the ward's objection in order to establish or restore the ward's competence to make treatment decisions. If the defendant who is competent to make treatment decisions but incompetent to stand trial, or if the guardian, acting on behalf of the ward, refuses medication, then the full evaluation of involuntary medication—demonstration of a compelling government interest, and the protection of the defendant's trial-related rights—must be undertaken.

2. INVOLUNTARY PSYCHOTROPIC MEDICATION OF ANYONE—INCLUDING A CRIMINAL DEFENDANT—INVOLVES A FUNDAMENTAL INTRUSION ON CONSTITUTIONALLY PROTECTED AUTONOMY.

Involuntary inpatient mental health treatment, in the form of commitment, represents a substantial deprivation of liberty protected by due process.³⁰³ The Court has recognized this deprivation of liberty from commitment as “more than [just] a loss of freedom from confinement,³⁰⁴ but also includes adverse social consequences.”³⁰⁵ Whatever deprivation of liberty involuntary, inpatient mental health treatment in general represents, involuntary medication—through perhaps forcible intrusion into a non-consenting person's body—is a “substantial interference with that person's liberty.”³⁰⁶ The interference arises from both the intrusion on bodily integrity inherent in the process of medication, and from the unconsented effect on mental processes, including thought and speech; this interference exists regardless of whether the person subjected to it is a criminal defendant or not, pretrial or convicted.³⁰⁷ This degree of intrusion merits the highest degree of constitutional scrutiny, “strict

302. The use of a guardian in cases where involuntary treatment is undertaken is routine, and cases that happen to involve a criminal defendant—while ultimately raising additional questions concerning the defendant's trial-related rights, because of the additional inquiry related to competence to stand trial—may similarly require a guardian.

303. See *Jones v. United States*, 463 U.S. 354, 361 (1983) (“Commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.”) (citing *Addington v. Texas*, 441 U.S. 418, 425 (1979)).

304. *Vitek*, 445 U.S. at 492.

305. *Id.*

306. See *Harper*, 494 U.S. at 229; accord *Riggins*, 504 U.S. at 134.

307. See *Foucha*, 504 U.S. at 73 (holding that due process restricts involuntary commitment and treatment in mental hospital of insanity acquittee who is no longer mentally ill); *Hendricks*, 521 U.S. at 357 (due process applies to, but permits, indefinite commitment for treatment of sexually dangerous person).

scrutiny,” before it can be undertaken.³⁰⁸ The government must thus demonstrate a compelling government interest in undertaking involuntary medication, and there must be a finding that such medication is the least intrusive means of accomplishing this interest.

3. A CRIMINAL DEFENDANT HAS NO CONSTITUTIONAL RIGHT TO BE, OR REMAIN, INCOMPETENT TO STAND TRIAL.

The government’s interest in bringing to trial persons, about whom there is probable cause to believe have committed crimes, is unquestionably a “compelling interest.”³⁰⁹ Permitting a defendant to choose to discontinue medication that makes them competent—and restricting the use of involuntary medication that would make them competent—certainly frustrates this interest. The constitutionally significant aspects of involuntary medication, however, are not that it makes the defendant competent to stand trial. The constitutionally significant implications of involuntary psychotropic medication are the way it is administered (intrusively), the effect it has on the defendant (altering the mental processes) and the positive or negative effects it can have upon the trial process (altering the defendant’s ability to interact with counsel, participate in the trial, and present himself to the jury testimonially or otherwise). Several conditions can render a defendant incompetent to stand trial, but remedying them does not implicate these constitutional aspects, either because remedying them does not require the intrusive administration of anything because it has no effect on the defendant’s mental processes or it has no effect upon the defendant’s participation in the trial process. For instance, the extremely tired defendant can be given rest before being put to trial, and the intoxicated defendant can be given time to become sober before trial. Likewise, the defendant who does not speak English cannot consult with his English-speaking lawyer with a reasonable degree of rational understanding and may lack virtually all understanding of the proceedings, but the provision of an interpreter does not alter his thoughts in interacting with counsel or his presentation of himself to the jury. The cognitively impaired or uneducated defendant who cannot understand the role of her lawyer, for

308. The Court in *Riggins* added to the jurisprudential confusion by not invoking strict scrutiny, *see supra* notes 85-93, and by failing to set any particular substantive standard for the intrusion. In *Weston*, for example, the district court—faced with the third remand of the case (after which the Court of Appeals did not prescribe a substantive standard)—appears to implement strict scrutiny without admitting so. *See Weston*, 2001 U.S. Dist. LEXIS 2486, at *47 (resisting a “bright line rule,” but finding that bringing *Weston* to trial—and therefore establishment of *Weston*’s competence to stand trial—is an “essential interest,” that medication is medically appropriate and it is least intrusive means to meet this “essential government interest”).

309. *Kelley v. Johnson*, 425 U.S. 238, 247 (1976) (“The promotion of safety of persons and property is unquestionably at the core of the State’s police power.”).

example, can be trained or educated as to the roles of the participants in the process without in any way impairing her own participation in the process. There is no right to remain incompetent to stand trial, only a right to be free from, or have limited, certain constitutionally significant implications of the *remedy* for the lack of competence.

4. MENTAL HEALTH CONDITIONS RENDERING ONE IMMINENTLY DANGEROUS JUSTIFY EMERGENCY INVOLUNTARY PSYCHOTROPIC MEDICATION, NOTWITHSTANDING ONE'S STATUS AS A PRETRIAL CRIMINAL DEFENDANT, BUT GENERAL STANDARDS FOR MEDICATION FOR THE PURPOSE OF RESTORING COMPETENCE TO STAND TRIAL CANNOT BE BASED SOLELY UPON EMERGENCY OR DANGEROUSNESS REQUIREMENTS.

The power to provide emergency, involuntary treatment—when someone presents a danger to himself or others—is well-established.³¹⁰ But addressing, on an emergency basis, danger from a defendant who may imminently harm himself or others, can also have the effect of changing the defendant's competence to stand trial—and influencing his ability to exercise his trial-related rights. This effect could be wholly dispositive on the defendant's legal case. Factors affecting determinations about treatment on a genuinely emergency basis cannot substitute for established standards for ongoing involuntary medication. The standards for involuntary medication prior to a planned event that can be scheduled, such as trial, should not be based upon such temporary conditions.

Similarly, the power to civilly commit persons who, because of mental illness, are a danger to themselves or others is also well established.³¹¹ However, treatment to restore competence to stand trial on the basis of imminent harm—which can range from a substantial risk of bodily harm to a simple risk of emotional harm—that could be undertaken if the defendant were incompetent to make treatment decisions and civilly committed, cannot become a general basis for involuntary medication of those who happen to be under legal control because of their criminal case. Defendants in criminal cases have additional legal rights that need to be protected. While ongoing conditions, including dangerousness, can be a basis for involuntary medication,³¹² they cannot be the sole basis for involuntary treatment to restore competence to stand trial.

310. MELTON ET AL., *supra* note 66, § 10.04(a)(1), at 313-14.

311. *Jackson v. Indiana*, 406 U.S. 715 (1972).

312. *See, e.g., Harper*, 494 U.S. 210.

5. RESTORING OR MAINTAINING A CRIMINAL DEFENDANT'S COMPETENCE TO STAND TRIAL, THROUGH INVOLUNTARY PSYCHOTROPIC MEDICATION, MAY BE A COMPELLING GOVERNMENT INTEREST.

Much indeterminacy in the Court's jurisprudence has been due to the fact that the Court has not definitively answered whether restoration to competency in order to stand trial is a compelling government interest. Bringing a criminal defendant to trial has been held to be an important government interest.³¹³ Similarly, establishing a defendant's competence to stand trial may, in some cases, be a compelling interest. Whether this is so will depend upon considerations about the particular case: the seriousness of the offense, the likelihood that the defendant will at some point regain competence without medication and the effect on the government's ability to bring the defendant to trial after such a delay.³¹⁴ Long delays in the trial proceedings can also affect the government's ability to bring the case to trial independent of any impact on the defendant—because over time witnesses may disappear, evidence can be lost and memories may fade.

The idea that competence is highly contextual is not without precedent. Whether a defendant who suffers from amnesia, for example, can be competent to stand trial presents a similar problem. Whether an amnesic defendant can consult with counsel to a reasonable degree of rational understanding has been held to require such a searching, case-specific inquiry, in order to determine whether the defendant's loss of memory did in fact deprive him of a fair trial and the effective assistance of counsel. One court described the scope of issues requiring inquiry this way:

- (1) The extent to which the amnesia affected the defendant's ability to consult with and assist his lawyer.
- (2) The extent to which the amnesia affected the defendant's ability to testify in

313. *Winston v. Lee*, 470 U.S. 753, 762 (1985) (holding “the community’s interest in fairly and accurately determining guilt or innocence . . . is of course of great importance,” but that involuntary surgery to remove bullet with possible evidentiary value required consideration of defendant’s right to privacy, security and bodily integrity); *Illinois v. Allen*, 397 U.S. 337, 347-48 (1970) (Brennan, J., concurring) (power to bring defendant to trial is fundamental to scheme of ordered liberty).

314. It may even be that any risk to competency can be minimized through the trial’s schedule. For example, in *Posby*, 574 N.W.2d 398, the defendant—who had been medicated and affirmed his competency throughout trial, sought discontinuation of his medication only at the end of the trial so that he could testify in an unmedicated state.

Thus, taking defendant off the medication for only three days so that he could testify in an unmedicated state did not implicate the question of competency during trial. Defendant had already assisted in his defense and there would not have been any further adjournments needed . . . because the defendant would then be administered the medication immediately after testifying.

Id. at 401.

his own behalf. (3) The extent to which the evidence in suit could be extrinsically reconstructed in view of the defendant's amnesia. Such evidence would include evidence relating to the crime itself as well as any reasonably possible alibi. (4) The extent to which the Government assisted the defendant and his counsel in that reconstruction. (5) The strength of the prosecution's case. Most important here will be whether the Government's case is such as to negate all reasonable hypotheses of innocence. If there is any substantial possibility that the accused could, but for his amnesia, establish an alibi or other defense, it should be presumed that he would have been able to do so. (6) Any other facts and circumstances which would indicate whether or not the defendant had a fair trial.³¹⁵

In cases in which the defendant's amnesia will not preclude his receiving effective assistance of counsel and a fair trial, the defendant's trial-related rights will have been protected. Similarly, in cases in which the defendant's competence can be achieved only through involuntary medication, a determination of whether the interest in establishing competency is sufficient should not only involve the type of factors listed above, but also the seriousness of the case, and the effect on the government's interest in ultimately prosecuting the matter if establishing competence involves extensive delay. That there is no simple test for the degree to which the government's interest in obtaining evidence can be balanced against the burden obtaining it poses for a criminal defendant is hardly new.³¹⁶

6. RESTORING OR MAINTAINING A CRIMINAL DEFENDANT'S COMPETENCE TO STAND TRIAL—THROUGH INVOLUNTARY PSYCHOTROPIC MEDICATION—MAY IMPLICATE SPECIFIC TRIAL-RELATED RIGHTS, WHICH MUST BE INDEPENDENTLY PROTECTED ANYTIME INVOLUNTARY MEDICATION IS UNDERTAKEN.

Involuntary psychotropic medication, unlike giving someone a chance to sleep or wear off the effects of intoxication may, depending on the medication, significantly affect a defendant's ability to enforce and use certain trial-related rights, including the right to effective assistance of counsel, to testify in one's own defense, and to put forth a defense. The defendant's inability to maintain or conduct himself appropriately in court might also justify burdening the constitutionally-protected autonomy. Because a determination that some such justification for burdening

315. *Wilson v. United States*, 391 F.2d 460, 463-64 (D.C. Cir. 1968).

316. *See Lee*, 470 U.S. at 760 (1985) ("In a given case, the question whether the community's need for evidence outweighs the substantial privacy interests at stake is a delicate one admitting of few categorical answers.").

autonomy exists implicates trial-related rights, the determination must be made in a procedural context which thoroughly and thoughtfully considers these legal and medical consequences. The proper procedural context for such a determination is the court with jurisdiction over the criminal charge.

The specific trial-related rights that may be implicated by involuntary medication, however, require that a medication determination be made in a process that guarantees the defendant the full opportunity to make the legal claims and case necessary to protect his trial-related rights.³¹⁷ Thus the determination of ongoing dangerousness, or that the safety of the defendant or others requires medication, or that restoration to competence or maintenance thereof requires involuntary medication, should be done only after a judicial hearing at which the government makes a showing which satisfies the most demanding standards for the burdening of fundamental rights. This should be a demonstration of compelling government interest, with involuntary medication being the most narrowly tailored means to achieve this interest; the finding should be made in a judicial hearing in which the government bears the burden of proof by clear and convincing evidence. Where the alleged compelling government interest is the dangerousness of the defendant, for example, the government should be obliged to explain why traditional alternatives available to protect the defendant and others, for instance commitment to a hospital, are inadequate.

The impact of the medication must be assessed both in direct and indirect terms. This means that the medication's intended and unintended effects must be evaluated in terms of their direct impact on the defendant's ability to exercise his trial-related rights and on their indirect impact on these rights. These effects require careful assessment, and perhaps case-specific remedies. The use of pre-medication records (such as videotapes) of the defendant's behavior and demeanor,³¹⁸ may be one alternative, as long as the feasibility of such a solution (and medical appropriateness, if the tapes were not created prior to the start of medication) is considered.

317. As previously noted, in a genuine emergency situation, which almost by definition involves dangerousness, no hearing is necessary. This exception to the need for a hearing, however, extends only to enable the medication necessary to respond to the emergency situation.

318. *Weston*, 206 F.3d at 21-22 (Tatel, J., concurring) (discussing possible use of videotaped interviews with government psychiatrist as means of protecting defendant's right to present defense and receive effective assistance of counsel).

7. MAINTAINING OR RESTORING THE DEFENDANT'S COMPETENCE TO STAND TRIAL CANNOT ALONE JUSTIFY INVOLUNTARY PSYCHOTROPIC MEDICATION WITHOUT A SEARCHING INQUIRY THAT MEDICATIONS ARE MEDICALLY APPROPRIATE, THAT THERE IS NO LESS INTRUSIVE ALTERNATIVE TO ACHIEVE COMPETENCE, AND THAT THE DEFENDANT'S TRIAL-RELATED RIGHTS ARE PROTECTED.

There remains a fundamental conflict between the principle that a criminal defendant has no right to remain incompetent to stand trial and the principle that, because of the mechanisms of involuntary psychotropic medication and its impact on the defendant's participation in the trial process, the process of establishing or restoring competence to stand trial can undermine the fairness of the trial or process of preparing for it. Thus, the establishment or restoration of competence alone cannot be a basis for involuntary medication without a searching inquiry determination that medication is medically appropriate, and that it provides the least intrusive means for establishing or restoring competence.

Winick, for example, has identified a range or continuum of interventions, arranged according to their intrusiveness on the patient. Involuntary psychotropic medication is among the more, but arguably hardly the most, intrusive on a continuum of interventions.³¹⁹ These range from the least intrusive, such as psychotherapy and behavioral therapy, through medication to electroconvulsive therapy, electronic stimulation of the brain and even surgery. Programs used to restore a defendant's competence to stand trial are offered in many jurisdictions in hospitals, in jails, and even in the community. These programs generally seek to identify the nuances of what makes a person incompetent to stand trial, and attempt to address these issues with medications, education, cognitive skill development and the like.³²⁰ With that in mind, a determination of the full range of available or potentially available means to establish or restore competence to stand trial must also be considered. All less intrusive means must be thoroughly explored—ideally through both expert testimony and trial attempts, unless they are not medically appropriate. The principle of considering reasonable alternatives is well-

319. See WINICK, *supra* note 272, at 29-119, 321.

320. K.T. Nelson, *The Patient-litigant's Knowledge of the Law: Importance in Treatment to Restore Sanity and in Competency Proceedings*, 7 AM. J. FORENSIC PSYCHOLOGY 29 (1989); D.L. Davis, *Treatment Planning for the Patient who is Incompetent to Stand Trial*, 36 HOSP. & COMMUNITY PSYCHIATRY 268 (1985); L. Pendleton, *Treatment of Persons found Incompetent to Stand Trial*, 137 AM. J. PSYCHIATRY 1098 (1980).

established in the law of involuntary medication for other purposes, and it is equally apt here.³²¹

This conflict between the lack of a right to remain incompetent to stand trial and the risk to the right to a fair trial is particularly acute where the restoration to competence through involuntary medication deprives the defendant of evidence concerning his state of mind at the time of the crime. For those defendants who offer a defense based upon mental state at the time of the offense, there can be a fundamental and severe problem.³²² One way out of this dilemma would be a requirement that whenever the government is able to make the requisite showing, remedial measures which protect the defendant's trial-related rights, must be guaranteed. At the minimum, they can include instructions to the jury concerning the presence and effect of psychotropic medication.³²³ They might also include the opportunity to make a record of the defendant's unmedicated state (and the requisite time, and resources if the defendant is indigent, to do this) if to do so is medically reasonable,³²⁴ to offer expert testimony concerning this record or the medication, or expert and lay testimony concerning the defendant's behavior in an unmedicated condition.

The guarantee of these measures to enforce the defendant's independent trial-related rights does not in itself satisfy the government's burden of showing that involuntary medication is a narrowly tailored means to satisfy a compelling government interest. Establishing competence to stand trial may, in some cases, be such a compelling interest. The effect on the defendant's trial-related rights must also be considered both directly and indirectly. It must be assessed directly, through effect on the defendant's ability to obtain a fair trial, to obtain the effective assistance of counsel (by effectively interacting with counsel), to testify and present his own version of events, to be present and to present a defense. It must also be assessed indirectly, through effect of the

321. *See, e.g.*, *Rogers v. Okin*, 634 F.2d 650, 656 (1st Cir. 1980) (before medication permissible, "reasonable alternatives to [involuntary] administration of antipsychotic medication must be ruled out").

322. *Louraine*, 453 N.E.2d 437 (defendant's right to fair trial denied by deprivation of opportunity to place his true demeanor before jury, and to present his version of the facts).

323. *See, e.g.*, *Lawrence v. State*, 454 S.E.2d 446, 452 (1995) (holding defendant not entitled to have jury view him in undrugged state, but is entitled on motion to have jury informed of medication prior to trial and in jury charge, that it may affect defendant's behavior in jury's presence and that if insanity defense is offered, it is to be evaluated as of time acts were committed).

324. Federal law permits a very limited version of this. When a federal criminal defendant is hospitalized, either because he has been found not competent to stand trial, has been found not guilty by reason of insanity, or has been found to suffer a mental disease or defect and is convicted, imprisoned, or due for release, 18 U.S.C. § 4247(f) provides that the defendant may have his testimony or forensic interview videotaped.

medication on the fact finder's assessment of defendant's demeanor, appearance and credibility.

8. ADVANCES IN PSYCHOTROPIC MEDICATIONS, UPDATED INFORMATION CONCERNING SIDE EFFECTS OF TRADITIONAL ANTIPSYCHOTIC MEDICATIONS, AND AN UNDERSTANDING OF THE IMPACT OF ALLOWING A PERSON TO REMAIN UNTREATED, REQUIRE HIGHLY CASE-SPECIFIC CONSIDERATION OF INVOLUNTARY MEDICATION.

The questions regarding medications raised by the *Weston* case are critical. However, the advances in medications used to treat psychotic illnesses have allowed for improved efficacy in the treatment of both positive symptoms (such as hearing voices, having delusional beliefs, or disorganized thoughts) and negative symptoms (such as social isolation, apathy, or emotional flattening) of serious mental illnesses. Furthermore, the side effects identified in previous court cases as being detrimental to a defendant's competence to stand trial were overstated, and were principally associated with the traditional antipsychotics. This is especially the case in light of the notion that most medications achieve a normalizing effect on a psychotic person,³²⁵ in that the side effects in no way compare to the actual symptoms of the illnesses in terms of their potential to be debilitating. Furthermore, because of a wider array of options available to treat psychotic illnesses, medication alternatives such as lowering doses, using medications to ameliorate side effects, or changing antipsychotic medication altogether offer a possible solution to issues related to side effect-induced deficits in competence to stand trial.

In addition, the impact of allowing a person to remain untreated can have enormous costs to the defendant³²⁶ and to society. Although a brief period off of medication may not necessarily be dangerous if adequate safeguards exist, it is unclear whether brief unmedicated periods would provide concrete evidence of a person's presentation of symptoms at the time of an alleged offense. Thus, it would be prudent to weigh the individual case and its potential solutions carefully, with the use of expert medical testimony as needed to educate the triers of fact about medication effects and the nature of the defendant's illness.

B. Procedural Issues

When a criminal defendant faces the possibility of involuntary medication, the procedures undertaken to determine the need for, appropriateness and permissibility of medication should be fundamentally

325. Gutheil & Appelbaum, *supra* note 97, at 95.

326. Jeffrey A. Lieberman & Wayne S. Fenton, *Delayed Detection of Psychosis: Causes, Consequences, and the Effect on Public Health*, 157 AM. J. PSYCHIATRY 1727, 1727-28 (2000).

legal, rather than medical, ones. Nevertheless, the procedure must be implemented with a careful and nuanced consideration of the medical issues involved, that will almost always necessitate expert clinical or medical testimony, that must be ongoing, and that must recognize the fluid nature of mental health conditions—particularly psychotic conditions. The legal procedures must be undertaken with a recognition that the time they require can itself impact the defendant’s mental health.

1. WHO SHOULD MAKE THE INVOLUNTARY MEDICATION DECISION?

When an individual is subjected to involuntary psychotropic medication, the decision maker may be either a court or an administrative body within the hospital or correctional facility, typically comprised of psychiatrists. Full consideration of the *Matthews v. Eldridge*³²⁷ factors, specifically the private interests at stake and the value of procedural requirements in determining what process is due, strongly suggest that a court rather than an administrative body make the decision concerning involuntary medication. Whether medication is “medically appropriate,” in the sense of whether it will relieve the defendant’s symptoms, is certainly a medical decision that will call for expert medical testimony. Likewise, the effects of medication discontinuation should call for expert medical commentary, as the discontinuation of psychotropic medication will not lead to a predictable outcome for any given individual. The private interests at stake, however, are not simply relief of the symptoms of mental illness.

The protection and vindication of a defendant’s constitutional trial rights are also compelling interests. These issues require consideration of the defendant’s mental health conditions in the context of the criminal case against him. They require consideration of the evidence that he will face, the type of defense he might raise, the need for his testimony, and the role of witness credibility in the case. They also require consideration of the ways medications affect the presentation of evidence, thus necessitating medical testimony. These effects may require consideration of what alternative methods of presenting evidence exist. In general, if the defendant is viewed as a patient, treating medical professionals would prefer a model of decision-making based on the treatment needs of the individual.³²⁸ However, from a judicial perspective the complexity of the legal issues lead legal professionals to favor judicial decision making, in order to comprehensively assess the rights of the individual, while weighing the medical needs based on expert medical testimony. These

327. 424 U.S. 319, 335 (1976).

328. Steven K. Hoge, *Treatment Refusal in Psychiatric Practice*, in THE PRINCIPLES AND PRACTICE OF FORENSIC PSYCHIATRY 127, 127-32 (Richard Rosner, ed., 1994).

are the type of decisions to which a court, rather than a body of medical professionals, is uniquely qualified to make.

2. WHAT TYPE OF PROCEEDING SHOULD BE REQUIRED?

The proceeding to determine whether involuntary medication of a pretrial criminal defendant will occur must take place before a judge with the same jurisdiction as the judge handling the criminal case, because the issues involving the defendant's trial-related rights are those typically addressed by such as judge. Issues concerning the safety, efficacy and alternatives to psychotropic medication, in addition to issues regarding a defendant's competence to make medical decisions, naturally call for expert medical testimony, and the initial portion of the proceeding should address these questions. Full consideration of the defendant's trial-related constitutional rights, however, requires consideration of the effects of medication in the legal context of the case, in order to determine whether the government's interest in establishing competence is compelling. This demands an understanding of the likely facts, theories and defenses in the case, the type of evidence, how the evidence will be adduced, and consideration of the relative factual complexity and degree to which the case will depend upon the unique knowledge of the defendant. It will also depend upon the degree that issues of credibility are at stake. These are the types of issues criminal trial judges deal with routinely. They are simply not matters which physicians, hospital administrators, or mental health professionals routinely encounter.

The sheer passage of time involved in conducting these proceedings could negatively impact a defendant, but the argument that proceedings such as this will all be time-consuming, costly and complicated should not be a basis for avoiding them.³²⁹ The proceeding thus should not only be before the criminal court judge, but it should be a full trial-like proceeding with counsel, the opportunity for cross examination and confrontation, and the opportunity to present evidence. The types of administrative hearings Russell Weston underwent, for example, in which

329. The goals of clinicians and lawyers may run counter to each other here. From a medical perspective, timely treatment is part of best practices, and these proceedings impede best practices. See Steven K. Hoge et al., *A Prospective, Multicenter Study of Patients' Refusal of Antipsychotic Medication*, 47 ARCHIVES GEN. PSYCHIATRY 949 (1990); Ronlad Schouten & Thomas G. Gutheil, *Aftermath of the Rogers Decision: Assessing the Costs*, 147 AM. J. PSYCHIATRY 1348 (1990). From a legal perspective, hearings ensure the legitimacy of the involuntary treatment process. Perlin, for example, has reviewed empirical studies of the actual cost and difficulty of hearings at which involuntarily committed persons were given the opportunity to refuse treatment. Based on these studies of "what actually happens when a right-to-refuse-treatment order is entered," he concluded "[t]he studies virtually unanimously belie the fear of creating an expensive, time-consuming, counterproductive layer of due process hearings." PERLIN, *supra* note 120, at 138.

consideration of expert testimony was done without the opportunity for probing examination by a lawyer, and no consideration whatsoever was given to the effect of medication on his trial-related rights, would be insufficient.

The Court has identified, in *Vitek v. Jones*³³⁰ a decision-making process it found constitutionally adequate before persons already convicted could be subjected to involuntary mental health treatment. The requirement in *Vitek* included the right to notice, the right to counsel, the opportunity to be heard, the right to present evidence, the right to confront and cross examine adverse witnesses, the right to a written ruling and the right to the effective and timely notice of these rights.³³¹ A defendant who has not yet been convicted of an offense presumably requires at least this level of a proceeding.

3. WHAT BURDEN OF PROOF SHOULD BE REQUIRED, AND UPON WHOM SHOULD IT BE PLACED?

Once the defendant seeks to end or avoid medication, the state becomes “obligated to establish the need for [the medication] and the medical appropriateness of the drug.”³³² Thus the defendant should not have to prove that, without medication, he will remain competent.³³³ This burden should be discharged, given the high substantive standard the government must meet, by evidence that is clear and convincing.³³⁴ Not only must this be a judicial hearing in which the government bears the burden by clear and convincing proof, but any order for involuntary medication must include periodic reviews to establish the continuing need for treatment and to assess the defendant’s current competence to stand trial.³³⁵

CONCLUSION

It would be particularly ironic if the significant advances in treatment of some of the most severe forms of mental illness, which have arisen in the past decade, were either not recognized by the Court, or became the basis for the Court’s ignoring or frustrating, through avoidance of the necessary inquiry, the rights of the already vulnerable population of mentally ill criminal defendants.

330. 445 U.S. 480 (1980).

331. *Vitek*, 445 U.S. at 494.

332. *Riggins*, 504 U.S. at 135.

333. See *Odiaga*, 871 P.2d at 804; accord *Garcia*, 658 A.2d at 965.

334. The parties in *Weston* agreed that this standard is appropriate. See *Weston*, 2001 U.S. Dist. LEXIS 2486, at *13 n.12.

335. In *Weston*, for example, the Court ordered monthly reports on the defendant’s treatment. *Id.* at *63.

Needless to say, the Court's existing jurisprudence concerning involuntary psychotropic medication of the criminal defendant has numerous shortcomings, and it will become a larger and more significant problem in the future. Of the two principal views concerning how determinations concerning the permissibility of involuntary medication are made, the functional view better takes account of the autonomy-based interests at stake for the pretrial criminal defendant. The principles laid out in this Article should guide the Court in fashioning a new jurisprudence, and in developing the procedural elements the jurisprudence should include in order to adequately protect the autonomy interests of a pretrial defendant.

Insert Appendix pages here (2pp)