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SELL'S CONUNDRUMS: THE RIGHT OF INCOMPETENT DEFENDANTS TO REFUSE ANTI-PSYCHOTIC MEDICATION

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ABSTRACT

The Supreme Court's 2003 decision in Sell v. United States declared that situations in which the state is authorized to forcibly medicate a criminal defendant to restore competency to stand trial "may be rare." Experience since Sell indicates that this prediction was wrong. In fact, wittingly or not, Sell created three exceptions to its holding (the dangerousness, treatment incompetency, and serious crime exceptions) that virtually swallow the right to refuse. Using the still-on-going case of Jared Loughner as an illustration, this essay explores the scope of these exceptions and the dispositions available in those rare circumstances when none of them is met. It concludes that Sell has created an unnecessarily complicated and often counter-productive legal regime that should be abandoned in favour of the regime that pre-existed it.

I. INTRODUCTION

In *Sell v. United States*,¹ decided in 2003, the Supreme Court stated that instances in which criminal defendants could be forcibly medicated to restore their trial competency "may be rare."² That casual declaration sent forensic hospital staff members all over the country into a panic. Since the treatment of choice for restoring defendants who are mentally ill is medication,³ and since upwards of 75 percent of those found incompetent

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1. 539 U.S. 166 (2003).

2. *Id.* at 180.

3. This, at least, is the view of the American Psychiatric Association. See Brief of American Psychiatric Association and American Academy of Psychiatry and the Law as *Amici Curiae* in Support of Neither Party and supporting Affirmance at 12, *United States v. Loughner*, No. 11-10339, 2011 WL 2694294 (9th Cir. July 12, 2011) ("Antipsychotic medications are an accepted and often irreplaceable treatment for acute psychotic illnesses, as most firmly established for schizophrenia, because the benefits of antipsychotic medications, compared to any other available means of treatment, outweigh their acknowledged side effects."). *But see infra* note 76.

to proceed refuse medication at one time or another,⁴ the Court's language sounded like a death-knell for forensic treatment programs. It also raised the specter of thousands of criminal defendants, now alerted to the fact that a treatment refusal might prevent prosecution, either languishing in mental hospitals or obtaining outright release.

But none of this has occurred. It is true that *Sell* has inspired trial courts to be much more careful in determining whether forcible medication of incompetent defendants may take place.⁵ And, as a result, medication hearings—most conspicuous among them those recently held in connection with the prosecution of Jared Lee Loughner, the accused shooter of Congresswoman Gabrielle Giffords and 20 others—have proliferated, especially at the federal level.⁶ But hidden or not so hidden within *Sell* were three exceptions to the general prohibition on involuntary medication—what this essay will call the *dangerousness*, *treatment incompetency*, and *serious crime* exceptions—that have enabled the restoration process to run almost as smoothly as it did pre-*Sell*, at least in the run-of-the-mill case.

At the same time, *Sell* introduced a number of conundrums into the law of medication refusal and competency restoration. First, the scope of the aforementioned exceptions is very unclear. When is a person “dangerous,” when is a person “incompetent to make treatment decisions,” and when is a crime “serious”? Second, *Sell* left up in the air the disposition of the rare individual who has a right to refuse medication and, as a result, cannot be tried. Is that individual entitled to the protection of *Jackson v. Indiana*,⁷ which held that an unrestorable person must be released or civilly committed, or does the fact that the person's unrestorability is due to a refusal change the analysis? Third, the Supreme Court's cases have yet to settle the extent to which courts, as opposed to some sort of administrative body, should be involved in all of these decisions.

This essay fleshes out these issues and a number of related conundrums by looking at lower court cases and in particular the case of Jared Loughner. It concludes that the complicated legal edifice constructed by *Sell* is conceptually flawed and should be replaced by a simpler rule:

4. Robert D. Miller et al., *The Impact of the Right to Refuse Treatment in a Forensic Patient Population: Six-Month Review*, 17 BULL. AM. ACAD. PSYCHIATRY & L. 107 (1989).

5. In this regard, however, *Sell* merely reinforced the Court's earlier decision in *Riggins v. Nevada*, 504 U.S. 127 (1992), discussed further *infra* note 15.

6. See Michelle R. Cruz, Case Summary, *United States v. Ruiz-Gaxiola: Setting the Standard for Medicating Defendants Involuntarily in the Ninth Circuit*, 41 GOLDEN GATE U. L. REV. 387, 398 n.118 (2011) (listing circuit court of appeals decisions interpreting and applying *Sell*).

7. 406 U.S. 715 (1972).

forcible medication of incompetent defendants charged with felonies should be permitted when the medication is a medically appropriate and essential method of restoring competency.

II. *SELL*'S EXCEPTIONS

The Supreme Court's decision in *Sell* was preceded ten years earlier by *Riggins v. Nevada*,⁸ which made clear that forcible medication in the pretrial setting must be "medically appropriate," as well as effective at and necessary to accomplishing the state's treatment aims. *Sell* strongly reaffirmed this aspect of *Riggins*.⁹ As a result, lower courts determining whether a defendant may be forcibly medicated have devoted considerable energy to investigating the side effects of proposed medication, its capacity to alleviate psychotic symptomatology without undermining the capacity to assist counsel and confront witnesses, and whether it is the only way competency can be restored.¹⁰

But *Sell* went well beyond endorsing *Riggins*' appropriateness, efficacy, and necessity requirements. Even if those requirements are met, *Sell* strongly implied that a defendant found incompetent to stand trial will often be able to refuse medication. The decision emphasized that, given the invasive and possibly harmful effects of anti-psychotic drugs, forcible medication is permissible only when "important" government interests are at stake.¹¹ Thus, as noted above, the Court concluded that such medication "may be rare."

Read closely, however, *Sell* sowed the seeds of its demise. In the course of explicating its holding, the opinion explicitly or implicitly recognized three exceptions to the right to refuse that come close to emasculating the right. The exception most explicitly announced in *Sell* occurs when the defendant is dangerous to self or others. The second exception, only briefly alluded to in *Sell*, arises when the defendant is incompetent to make treatment decisions. The third exception, also less than forthrightly announced in *Sell*, exists when the defendant is charged

8. 504 U.S. 127 (1992).

9. See, e.g., *Sell v. United States*, 539 U.S. 166, 179–81 (prohibiting involuntary medication of an accused for the purpose of restoring competency unless "the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests") (citing *Riggins*, 504 U.S. at 134–38 and *Washington v. Harper*, 494 U.S. 210, 225, 227 (1990)).

10. See *Cruz*, *supra* note 6, at 399–401.

11. See *Sell*, 539 U.S. at 180.

with a serious crime. Each one of these exceptions raises tough definitional problems. But even interpreted narrowly, together they virtually eliminate any right to refuse beyond that which *Riggins* already provides.

A. *The Dangerousness Exception*

Justice Breyer's majority opinion in *Sell* emphasized that, while forcible medication solely for the purpose of restoring competency might need to be significantly curtailed, "alternative grounds" for medicating individuals over their objection still existed.¹² This statement was followed by a citation to the Court's decision in *Washington v. Harper*,¹³ which held that a prisoner may be forcibly medicated if the government can show the medication is a "medically appropriate" way of treating "serious mental illness" that has made the individual "dangerous to himself or others."¹⁴ Because *Harper* had dealt with a convicted individual rather than an individual merely charged with crime, its relevance to the competency restoration context was not entirely clear at the time it was decided. But two years later, *Riggins* held that *Harper*'s rule applied to persons who have been accused of crime as well as prisoners, albeit with two major caveats. First, the medication has to be "essential" to protect the defendant's safety or the safety of others in light of "less intrusive alternatives."¹⁵ Second, if the state subsequently tries such a defendant it must also show that the medication does not affect his ability to comprehend criminal proceedings, interact with his attorney, or testify.¹⁶ *Riggins* recognized that too much medication, even if necessary to reduce dangerousness or accomplish some other legitimate aim, can make a defendant incompetent to proceed and thus untriable. Ten years later *Sell* affirmed both of these caveats.¹⁷

12. *Id.* at 182.

13. 494 U.S. 210 (1990).

14. *Id.* at 226–27.

15. *Id.* at 135–36. As *Sell* would later describe *Riggins*, "[t]he Court, citing *Harper*, noted that the State would have satisfied due process if the prosecution had demonstrated . . . that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of *Riggins' own safety or the safety of others.*" *Sell*, 539 U.S. at 179 (emphasis in original).

16. *Riggins*, 504 U.S. at 137 (trial judge's failure to consider the effects of antipsychotic medication "may well have impaired . . . constitutionally protected trial rights" because such effects could have "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.").

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

The key issue in applying the dangerousness exception, of course, is the definition of dangerousness. A narrow definition, adopted in many state civil commitment statutes, would require a showing that, without intervention, there is a “substantial likelihood” the individual will inflict “serious bodily harm” on himself or others “in the near future.”¹⁸ Somewhat less demanding is the definition found in the prison policy implicitly upheld in *Harper*: a “substantial risk” that failure to medicate will result either in physical harm to others or others’ property or in physical harm to self due to suicide, “a failure to provide . . . essential human needs of health and safety,” or “severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control . . .”¹⁹ Broader still is *Harper*’s aforementioned summary of its holding, using the simple formulation “dangerous to himself or others.”²⁰

These standards vary in terms of: (1) likelihood of harm; (2) magnitude of harm; (3) imminence of harm; and (4) frequency of harm.²¹ Unless the definition of dangerousness is very tight—at the least requiring a significant and imminent risk of serious bodily harm—the government could often disguise an attempt to restore a defendant to competency as treatment to alleviate danger. After all, the defendant has recently been charged with a crime, has been found incompetent to proceed, and is likely to exhibit at least some conditions or behaviors—depression, violent outbursts—that suggest a threat to self or others.

The proper definition of dangerousness is only the most obvious conundrum raised by this exception. *Sell* also followed *Riggins* in holding that involuntary medication under the dangerousness exception is impermissible if some other, “less intrusive” means is available to limit the danger posed.²² The question then arises as to whether less potent medication, cognitive therapy, or some other treatment might work. A number of courts have even been willing to contemplate the argument that seclusion and restraint is a less “intrusive” alternative to medication. For instance, in *United States v. Weston*,²³ the District of Columbia Circuit Court of Appeals held, prior to *Sell*, that “confinement—total seclusion

18. See, e.g., FLA. STAT. § 394.467(1)(a)(2)(b) (2012).

19. *Washington v. Harper*, 494 U.S. 210, 215 n.3 (1990).

20. *Id.* at 227.

21. See ALEXANDER D. BROOKS, *Dangerousness Defined*, in *LAW, PSYCHIATRY & MENTAL HEALTH SYSTEMS* 680 (Alexander Brooks ed., 1974).

22. See *supra* note 15.

23. 255 F.3d 873 (D.C. Cir. 2001).

and constant observation—obviated any significant danger [the defendant] might pose to himself or others.”²⁴

Jared Loughner’s case illustrates many of the nuances associated with the dangerousness exception. On March 3, 2011 a federal grand jury indicted Loughner on multiple charges, including the murder of a federal judge (John M. Roll) and several other federal employees and the attempted assassination of a member of Congress (Gabrielle Giffords).²⁵ Loughner was sent to the Federal Medical Center in Springfield, Missouri, for an evaluation of his competency. On May 25, based on this evaluation, the district court in Tucson, Arizona, found him incompetent to stand trial.²⁶ Upon return to Springfield in June, Loughner refused medication. During the next two weeks both an independent psychiatrist and the associate warden to whom Loughner appealed the psychiatrist’s decision concluded that anti-psychotic medication was in Loughner’s “best medical interest” and necessary to prevent him from being “dangerous to others.”²⁷

Loughner appealed these administrative decisions to the Tucson federal district court. On June 29, that court refused to stop the treatment, in light of evidence that Loughner had become enraged at a psychiatrist, thrown a plastic chair at him, spat at his attorney, and thrown a wet roll of toilet paper at a camera.²⁸ But three days later the defense team, led by Judy Clarke, an ex-public defender who has been involved in several high-profile cases, asked the Ninth Circuit for an emergency stay, which was granted on July 12. Echoing *Weston*, a three-judge panel of the Ninth Circuit, headed by Judge Kozinski, found that Loughner’s interest in avoiding the possible side effects of the medication was more “immediate” than the government interest in preventing harm to others, noting that the government “has managed to keep Loughner in custody for over six months without injury to anyone.”²⁹

That did not end the matter, however. A day after the oral arguments in front of the Ninth Circuit, Loughner was placed on suicide watch, and six

24. *Id.* at 878. Contrast this with *Harper*’s observation that restraints and seclusion may not be “acceptable substitutes for antipsychotic drugs, in terms of either their medical effectiveness or their toll on limited prison resources.” *Harper*, 494 U.S. at 226–27.

25. Response to Defendant’s Emergency Motion to Enforce Injunction and Compel Daily Production of BOP Records at 2–3, *United States v. Loughner*, No. 11-10339D (9th Cir., July 22, 2011), at 2–3 [hereinafter Response].

26. *Id.* at 3.

27. *Id.* at 4.

28. Tony Perry, *Suspected Tucson Gunman Can Be Forced to Take Antipsychotic Drugs*, *Judge Rules*, L.A. TIMES, June 30, 2011, <http://articles.latimes.com/2011/jun/30/nation/la-na-loughner-20110630>.

29. *United States v. Loughner*, No. 11-339, 2011 WL 2694294, at *2 (9th Cir. July 12, 2011).

days after the Ninth Circuit panel opinion was handed down the professionals at Springfield concluded that Loughner was “an immediate threat to *himself*” and thus still needed medication.³⁰ The government alleged that he was observed screaming loudly and crying for hours at a time and, when asked whether he had thoughts of harming himself, stated, “I want to die. Give me the injection, kill me now.”³¹ He was said to be disoriented and confused, limping because of his “prolonged walking, pacing and standing,” and in a deteriorating physical condition because he did not eat many of his meals and sometimes stayed awake for over twenty-four hours at a time.³² The defense argued that Loughner’s primary symptoms were “agitation and sleeplessness,” which could be addressed using minor tranquilizers,³³ and also suggested that the government’s course of conduct indicated a “willful violation” of the Ninth Circuit panel order.³⁴ The government insisted that Loughner was a true threat to himself and that anti-psychotic medication was the only method of eradicating the cause of that threat.³⁵ On July 22, the same Kozinski-led three-judge panel of the Ninth Circuit denied Loughner’s request for a continued injunction against medication.³⁶ In the ensuing months, Loughner continued to receive anti-psychotic drugs and, at the end of his first four-month commitment in September, the Ninth Circuit affirmed his commitment to the Federal Medical Center for an additional four months.³⁷

In early February 2012, Loughner’s commitment was extended for another four-month period.³⁸ In the meantime, a series of challenges to these actions were consolidated and heard by another three-judge panel from the Ninth Circuit, which handed down a forty-five-page decision on March 5, 2012.³⁹ Two judges, Bybee and Wallace, upheld the district

30. Response, *supra* note 25, at 11 (emphasis added).

31. *Id.* at 6.

32. *Id.*

33. Emergency Motion to Enforce Injunction and Compel Daily Production of BOP Records at 7, *United States v. Loughner*, No. 11-10339 (9th Cir., July 22, 2011) [hereinafter *Emergency Motion*].

34. *Id.* at 4.

35. Response, *supra* note 25, at 15 (“Loughner’s unmedicated behavior is endangering him, and . . . no measures short of medication will protect him from himself more than temporarily, because they do not address the mental state which underlies his self-destructive actions.”).

36. *United States v. Loughner*, Order, No. 11-10339 (9th Cir., July 22, 2011).

37. Carol J. Williams, *Loughner Loses Bid to Stay Out of Missouri Prison Hospital*, LOS ANGELES TIMES, Oct. 7, 2011, <http://latimesblogs.latimes.com/nationnow/2011/10/loughner-can-return-to-missouri-prison-hospital-appeals-court-rules.html>.

38. *United States v. Loughner*, Nos. 11-10339, 11-10504, 11-10432, 2012 WL 688805, at *7 n.6 (9th Cir. 2012).

39. *Id.*

court's medication and commitment orders, emphasizing that the hospital staff's decisions about dangerousness were entitled to deference and finding that the administrative procedures followed at Springfield were consistent with *Harper*.⁴⁰ Judge Berzon dissented, on the ground that the district court judge could not determine whether commitment was necessary to restore Loughner to competency without making an independent assessment of whether Loughner could be forcibly medicated to achieve that goal.⁴¹ Turning to the merits, Judge Berzon suggested that Loughner might not be sufficiently dangerous to justify forcible medication and that, even if he were, the treatment regimen designed to achieve that purpose might not restore him to competency or might undermine his Sixth Amendment trial rights.⁴²

The *Loughner* case illustrates several difficulties with *Sell*'s dangerousness exception. Are assaults sufficient evidence of danger to others, and are severe bouts of depression or significant sleep or eating disorders sufficient evidence of danger to self? In answering those questions, does it matter that seclusion, restraints, or anti-anxiety medication could reduce the danger, albeit on a temporary basis? The prosecution will be tempted to define dangerousness broadly and alternatives to medication narrowly in an effort to provide maximum protection to its employees and the defendant and, perhaps, also in the hope that the medication will restore competency. To avoid the latter result, the defense will argue for a narrow definition of dangerousness and a generous approach to options other than anti-psychotic drugs. As *Loughner* demonstrates, the fight over dangerousness may well be a proxy for the real fight: whether the government can forcibly medicate the individual in order to restore competency. Lost in this type of adversarial debate will be the psychological welfare of the defendant, who if not treated or treated unevenly could de-compensate beyond the point of no return.⁴³

40. *Id.* at *16–22. Although the majority opinion can be challenged on a number of grounds, the only clearly wrong aspect of the opinion was its holding that *Riggins* does not apply to pretrial determinations of dangerousness. Compare *id.* at *16 (“when the government seeks to medicate a detainee—whether pretrial or post-conviction—on the grounds that he is a danger . . . [t]he *Riggins* standard [requiring consideration of less intrusive alternatives essential for safety] does not govern.”) with *supra* note 15.

41. *Loughner*, 2012 WL 688805 at *49 (Berzon, J., dissenting).

42. *Id.* at *49–57.

43. The longer the duration between the onset of serious psychosis and treatment, the more likely long-term disability will result. Max Marshall et al., *Association Between Duration of Untreated Psychosis and Outcome in Cohorts of “First-Episode” Patients: A Systematic Review*, 62 ARCHIVES GEN. PSYCHIATRY 975 (2005). Furthermore, quick withdrawal from treatment, sought by the defense

Thus, a third conundrum arises in connection with this exception, at least for defense attorneys. Arguably, the defense has an ethical obligation not only to represent its client zealously but also to ensure the consequences of its arguments do not seriously harm the client.⁴⁴ The claim that advocacy against forcible medication is merely doing the client's bidding rings hollow in those cases where the client may not be competent to make treatment decisions (about which more below) or where a refusal by a competent defendant is driven by a desire to avoid prosecution rather than genuine concern about the effects of anti-psychotic medication.⁴⁵

Defense attorneys worried that the dangerousness exception will be used as an end-run around *Sell*'s prohibition should also consider two other points. First, the dangerousness exception, however defined, only permits treatment to the extent necessary to address the danger, which is not necessarily the same treatment regimen that would bring full restoration of competency; for instance, in *Loughner* the government doctors initially prescribed only one milligram of risperidone twice daily, well under the usual dose needed to overcome flagrant psychosis.⁴⁶ Furthermore, even if some semblance of competency does result from medication imposed on dangerousness grounds, recall that *Riggins* imposes a serious limitation on any trial that subsequently takes place. The court must ensure that the medication does not interfere with the defendant's trial rights, including the ability to follow the trial process, communicate with the attorney, and testify.⁴⁷

It remains unclear whether the dangerousness exception to *Sell* is a significant loophole.⁴⁸ Much depends on how dangerousness is defined,

in *Loughner*, is likely to be more damaging than slow withdrawal. See J. Moncrieff, *Does Antipsychotic Withdrawal Provoke Psychosis? Review of the Literature on Rapid Onset Psychosis (Supersensitivity Psychosis) and Withdrawal-Related Relapse*, 114 ACTA PSYCHIATRICA SCANDINAVICA 3 (2006).

44. The ethical issues raised in this setting are too complicated to address here. Suffice to say that the ethical rules do not provide any definitive answers. See, e.g., MODEL CODE OF PROF'L RESPONSIBILITY, Canon 7-12 (1980) ("If the disability of a client and the lack of a legal representative compel the lawyer to make decisions for his client, the lawyer should consider all circumstances then prevailing and act with care to safeguard and advance the interests of his client.").

45. Another purely strategic reason for medication refusal in a case like *Loughner*'s is to provide an incentive to the prosecution for abandoning the death penalty.

46. Emergency Motion, *supra* note 33, at 6-7.

47. Both first- and second-generation drugs can cause "mental clouding and sedation coupled to a profound loss of motivation which can persist for as long as the treatment continues." RICHARD BENTALL, DOCTORING THE MIND: IS OUR CURRENT TREATMENT OF MENTAL ILLNESS REALLY ANY GOOD? 229 (2009).

48. Of possible relevance here is the Supreme Court's strong insinuation in *Sell* that had it heard the case de novo it would have found *Sell* dangerous. *Sell v. United States*, 539 U.S. 166, 184-85

what alternatives to medication are considered less intrusive means of dealing with the danger, and the extent to which the medication compromises trial rights. What is clear is that, given its complications, the dangerousness exception is not the “easier” alternative ground that *Sell* suggests it is. What also *should* be clear, but apparently is not to those immersed in cases like *Loughner*’s, is that dangerousness is not the only exception to *Sell*’s admonition against forcible medication.

B. The Incompetence to Make Treatment Decisions Exception

After describing *Harper*’s holding, the Court in *Sell* stated that courts typically justify involuntary treatment relying on “these alternative, *Harper*-type grounds.”⁴⁹ But it went on to describe an alternative ground that is significantly different from *Harper*’s dangerousness exception: “Every state provides avenues through which, for example, a doctor or institution can seek appointment of a guardian with the power to make a decision authorizing medication—when in the best interests of a patient who lacks the mental competence to make such a decision.”⁵⁰ Although this language does not explicitly approve forcible medication in the lack-of-mental-competence situation, one paragraph later the Court again indicated that an individual who is either dangerous *or* “[in]competent to make up his own mind about treatment” may be forcibly medicated.⁵¹

Despite the fact that courts in the medical and civil commitment contexts have long recognized that patients who are incompetent to make treatment decisions may have the decision made for them,⁵² this second exception to the right to refuse is virtually never mentioned by courts implementing *Sell*. Even in *Loughner*, one of the most intensely litigated forcible competency cases since *Sell*, neither side has addressed the issue, nor have the courts. Perhaps that is because the treatment incompetence exception was only referenced obliquely in the *Sell* decision, sandwiched within a discussion of “*Harper*-type factors,” and thus has gone unnoticed.

(suggesting that the Court of Appeals had too easily dismissed *Sell*’s assault on a ward nurse and noting that the court did not explain how it arrived at its conclusion that *Sell* was not dangerous, given the fact “that the testifying psychiatrists concluded that *Sell* was dangerous, while *Sell*’s own expert denied, not *Sell*’s dangerousness, but the efficacy of the drugs proposed for treatment.”).

49. *Id.* at 182.

50. *Id.*

51. *Id.* at 183.

52. Even courts that have taken a strong stance in favor of the right to refuse recognize an exception when the “patient is incompetent to make a treatment decision.” *Rogers v. Comm’r of Dep’t of Mental Health*, 458 N.E.2d 308, 322 (Mass. 1983).

Or perhaps this aspect of *Sell* has received little consideration because, for reasons developed below, it comes close to rendering *Sell* irrelevant.

Two issues arise in connection with the treatment incompetence rationale for forcible medication. The first, the definition of incompetence to make a treatment decision, has received extensive attention in the literature.⁵³ My own view is that people are incompetent in this sense if: (1) they are unable to understand the risks and benefits of the treatment; (2) give delusional reasons for refusing it (e.g., “If I take the drugs the world will end,” or “If I undergo this treatment I’ll become pregnant.”); or (3) fail to consider reasons at all (usually as a result of severe depression).⁵⁴ Others have defined treatment incompetency more broadly, to include any evidence of significant pathology or an inability to manipulate the relevant risk-benefit information “rationally.”⁵⁵

If either of the last two tests (the significant pathology or inability-to-manipulate test) is adopted, then almost by definition defendants who are found incompetent to stand trial are also incompetent to make treatment decisions. The accepted standard for competency to proceed with trial comes from *Dusky v. United States*,⁵⁶ which held that a defendant is incompetent in this sense if he lacks “sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of proceedings against him.”⁵⁷ This is not an easy test to meet.⁵⁸ Defendants like Loughner who are found incompetent under *Dusky* are significantly impaired. They will certainly be experiencing pathological symptoms and difficulty rationally thinking about the risk and benefits of medication. Even under the narrower definition I prefer (noted above), many

53. See, e.g., ELYN SAKS, REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL (2002); Thomas Grisso & Paul Appelbaum, *Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 L. & HUM BEHAV. 149 (1995) (discussing different definitions of competency and reporting a study indicating that regardless of the test used, approximately 25% of the subjects with schizophrenia scored in the “impaired” range, compared with 5% of medical patients and 2% of non-treated individuals in the community).

54. CHRISTOPHER SLOBOGIN, MINDING JUSTICE: LAWS THAT DEPRIVE PEOPLE WITH MENTAL DISABILITY OF LIFE AND LIBERTY 233–35 (2006) (developing and defending the basic rationality and basic self-regard test for treatment competency).

55. See, e.g., Loren Roth et al., *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279, 283 (1977) (suggesting that the latter tests might be “legitimate” when there is “favorable risk benefit ratio to the proposed treatment,” which most psychiatrists probably feel is the case with antipsychotic medication).

56. 362 U.S. 402 (1960).

57. *Id.* at 402 (internal quotations omitted).

58. See RONALD ROESCH & STEPHEN GOLDING, COMPETENCY TO STAND TRIAL 48–49 (1980) (finding that, on average only about 30 percent of defendants who are referred for competency evaluations are found incompetent).

defendants found incompetent to proceed will be incompetent to make treatment decisions; in particular, if they do not meet prong (1) above because they cannot understand the risks and benefits of going to trial, pleading guilty, and waiving rights, they will probably not be able to understand the risks and benefits of treatment. Thus, on the surface at least, this exception to the right to refuse announced in *Sell* pretty much swallows the right.⁵⁹

Competency to proceed with trial and competency to make treatment decisions are not entirely congruent, however. Some defendants may not understand the nature or consequences of the trial process but understand the risks and benefits of treatment.⁶⁰ Some defendants may be found incompetent to proceed not because they lack understanding of relevant facts about the criminal process but because they express delusional reasoning about the trial process, while at the same time remaining able to give non-delusional reasons for refusing treatment. Thus, depending on how competency to make treatment decisions is defined, the Venn diagram depicting incompetency to proceed and incompetency to make treatment decisions leaves at least some independent, if tiny, spaces on each edge.

Moreover, even a person who is incompetent to make treatment decisions is not automatically subject to medication. As *Sell* indicated, a guardian or some other decision maker must additionally determine that the medication is in the individual's "best interests."⁶¹ This second issue connected with the incompetency exception is also a complicated one. Medication may not be in the person's best interests because of its side effects or its inefficacy at treating mental illness. Where, as here, criminal defendants are involved, a guardian might even include within the best-interests calculus the fact that treatment could lead to trial and conviction (although a good argument can be made that the latter possibility is irrelevant in this situation⁶²).

59. I made this point in SLOBOGIN, *supra* note 54, at 230. For fuller development of the argument, see Robert Schopp, *Involuntary Treatment and Competence to Proceed in the Criminal Process: Capital and Noncapital Cases*, 24 BEH. SCI. & L. 495, 502–10 (2006).

60. See NORMAN G. POYTHRESS ET AL., ADJUDICATIVE COMPETENCE: THE MACARTHUR STUDIES 108 (2002) (reporting empirical research on competence to stand trial that led the researchers to conclude that "impairment with respect to one legal issue is likely to be a poor proxy for impairment in another.").

61. *Sell v. United States*, 539 U.S. 166, 182 (2003).

62. *Cf.* Schopp, *supra* note 59, at 517 ("the determination that the involuntarily administered medication is, or is not, in the offender's medical interests . . . does not include the anticipated execution because the evaluation of the legitimacy of his capital sentence falls within the authority of the [courts].").

At the same time, the best-interests standard applied in this setting is not simply a determination of whether medication will prevent suicide or other serious harm to self, a formulation that would collapse this exception into the dangerousness exception. One could justifiably conclude that medication is in the best interests of an individual even if the person is not suicidal or in grave danger or deterioration, as long as the treatment improves his or her mental health.⁶³ And if medication is considered the best way of restoring a criminal defendant to treatment competency and mental health, then the fact that the defendant's competence to proceed might also be restored by the treatment should be irrelevant, even after *Sell*. In short, if this exception is taken seriously, most criminal defendants found incompetent to proceed do not have a right to refuse medication, even though that medication may well have the effect of restoring them to *Dusky* competence.

The conundrums raised by this exception are still not exhausted, however. What if the defendant is forcibly medicated under this exception and, once restored to treatment competency, decides to refuse medication? Does the defendant have a right to do so? If he or she is dangerous (see Exception One), presumably not. But what if dangerousness cannot be shown? This last question leads to the third exception.

C. *The Serious Crime Exception*

Sell stated that the involuntary administration of drugs to restore trial competence can occur if “important governmental interests are at stake,” which it indicated included the interest in prosecuting “serious crimes” against person or property.⁶⁴ That statement would seem to open the door wide to forcible competency restoration in most serious felony cases. The lower courts have used a variety of indicia for figuring out when a crime is serious for purposes of *Sell*,⁶⁵ but all appear to agree that homicide and

63. Consider, for instance, this definition of acting in a patient's “best interests”: “[P]romoting personal well-being by the assessment of the risks, benefits and alternatives to the patient of a proposed major medical treatment taking into account factors including the relief of suffering, the preservation or restoration of functioning, improvement in the quality of the patient's life with and without the proposed major medical treatment and consistency with personal beliefs and values known to be held by the patient.” *In re Beth Israel Medical Center*, 136 Misc. 2d 931, 938–39, 519 N.Y.S.2d 511, 516 (Sup. Ct. 1987) (quoting N.Y. MENTAL HYG. LAW § 80.03(d) (McKinney 1988)).

64. *Sell*, 539 U.S. at 180 (emphasis in original).

65. See, e.g., *United States v. Hernandez-Vasques*, 513 F.3d 908, 918–19 (9th Cir. 2008) (stating that the guidelines “are the best available predictor of the length of a defendant's incarceration”); *United States v. Valenzuela-Puentes*, 479 F.2d 1220, 1225 (10th Cir. 2007) (six to eight year maximum guidelines sentence for illegally entering the United States sufficiently serious, given defendant's long criminal history); *United States v. Evans*, 404 F.3d 227, 237–38 (4th Cir. 2005)

attempted homicide, as well as rape, armed robbery, and aggravated assault fit the bill.⁶⁶

Thus, even if the previous two exceptions do not apply to Jared Loughner, the serious crime exception would seem to provide obvious authority to medicate him over his objection, even if the sole purpose is to restore him to trial competency. However, *Sell* proceeded to muddy the water in this situation by indicating that the government's interest in prosecuting serious cases might be lessened by "special circumstances."⁶⁷ Specifically, the Court stated, "[t]he defendant's failure to take drugs voluntarily, for example, may mean lengthy confinement in an institution for the mentally ill—and that would diminish the risks that ordinarily attach to freeing without punishment one who has committed a serious crime."⁶⁸ The Court hastened to add that, by this statement, "[w]e do not mean to suggest that civil commitment is a substitute for a criminal trial."⁶⁹ But the Court's language contemplating "lengthy confinement in an institution for the mentally ill" is hard to read any other way, and lower courts have certainly done so.⁷⁰

The Court's "special circumstances" caveat to the serious crimes exception is incoherent for two reasons. First, civil commitment does not come close to achieving the government's aims in serious criminal cases. As the *Weston* court stated, this argument

assumes that the government's essential penological interests lie only in incapacitating dangerous offenders. It ignores the retributive, deterrent, communicative, and investigative functions of the criminal justice system, which serve to ensure that offenders receive their just deserts, to make clear that offenses entail consequences, and to discover what happened through the public mechanism of trial.⁷¹

(holding that the statutory maximum rather than the sentencing guidelines maximum is the appropriate benchmark because it determines the right to jury trial and because guidelines sentences cannot be predicted); *United States v. Dumeny*, 295 F. Supp. 2d 131, 132 (D. Me. 2004) (maximum ten-year sentence for possession of a firearm by person previously committed to a mental health institute not sufficiently serious).

66. *See Cruz*, *supra* note 6, at 399.

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

68. *Id.*

69. *Id.*

70. *See, e.g., United States v. Grape*, 549 F.3d 591, 601–03 (3d Cir. 2008) (addressing Grape's argument that civil commitment would accomplish the government's aims by concluding that "[i]t is no longer clear that Grape's punishment-incarceration, whether in prison or a medical facility, would be the same whether or not he were involuntary medicated.").

71. *United States v. Weston*, 255 F.3d 873, 882 (D.C. Cir. 2001).

Second, even if civil commitment did manage to achieve the prosecution's objectives, it is not available in this situation, because civil commitment requires proof of dangerousness to self or others.⁷² If such proof is forthcoming then forcible medication is permissible under *Sell*'s dangerousness exception. If the dangerousness exception does not apply, commitment should not be possible either.

Yet the Court's insinuation to the contrary was not an accident. Consider how the Court applied its holding to Charles Sell. After assuming that Sell was not dangerous, the majority chastised the lower courts for failing to include in their analysis not only the time Sell had already been incapacitated but the fact that "his refusal to take antipsychotic drugs might result in further lengthy confinement."⁷³ The Court was apparently oblivious to the fact that this part of *Sell* is a direct contradiction of its holding thirty years earlier in *O'Connor v. Donaldson*⁷⁴ that "there is . . . no constitutional basis for confining [people with mental illness] involuntarily if they are dangerous to no one and can live safely in freedom."⁷⁵ Under *Donaldson*, if Sell was not dangerous to self or others, as the Court assumed, then the state had no grounds to hold him.

In short, a strong argument can be made that the Court either should have avoided creating a serious crime exception (on the ground that the government's interest in prosecution can never trump the right to refuse), or it should have adopted the exception sans its caveat creating a new type of commitment. But as the next part explains, creation of the commitment option might have been necessary once the Court decided to allow competent, non-dangerous defendants to refuse medication. This dispositional conundrum may be the most mystifying of the lot.

III. DISPOSITION OF LEGITIMATE REFUSERS

Up to this point, the analysis of *Sell* has suggested that most criminal defendants found incompetent to proceed will not be able to refuse medically appropriate anti-psychotic medication that is necessary to restore trial competency. Either they will be charged with a serious crime and not be committable (the baby bear exception), or they will be

72. See GARY MELTON ET AL., *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS* 335 (3d ed. 2007) (stating that "[e]ach state also requires a finding that the individual is dangerous to self or others as a result of the mental disorder.").

73. *Sell*, 539 U.S. at 185 ("We must assume that Sell is not dangerous.").

74. 422 U.S. 563 (1975).

75. *Id.* at 575.

dangerous to self or others (the mama bear exception) or, most likely of all, they will be incompetent to make treatment decisions (the papa bear exception), and sometimes they will meet more than one exception. Furthermore, even involuntary medication solely for the purpose of restoring defendants to competency should be relatively common (in other words, should be permissible in *all* cases involving serious crime) if one agrees with the foregoing conclusion that commitment is not a legitimate alternative to prosecution in such cases.

However, as the previous part explained, the Court apparently does not agree with that analysis. Furthermore, even if a defendant is medicated under the dangerousness or incompetency exceptions and responds well to the medication, trial competence restoration may not result, given the differing treatment goals involved. Finally, even if one or more of the exceptions are met and competency is restorable, the *Riggins* criteria—medical appropriateness, efficacy, and necessity—may not be met. In all of these situations, refusal of anti-psychotic medication is permitted. And while some of these defendants may become competent to stand trial through means other than medication, many will not.⁷⁶

The issue for all of these individuals then becomes disposition. Prosecution is not possible, at least under current law.⁷⁷ Thus, the relevant rule would seem to be stated by *Jackson v. Indiana*,⁷⁸ which held that defendants who are not restorable to competency must be either civilly committed or released. Many of the individuals who are permitted to refuse solely because the *Riggins* criteria are not met may be committable, and the few who are not restored despite meeting the dangerousness exception will be as well. But the small number of individuals who are

76. Cognitive-behavioral therapy can benefit patients who are at risk for psychosis, patients who are drug-resistant, and patients who are also receiving medication. See, e.g., Nicholas Tarrier et al., *Cognitive-Behavioural Therapy in First-Episode and Early Schizophrenia: 18-Month Follow-up of a Randomised Controlled Trial*, 184 BRIT. J. PSYCHIATRY 231 (2004); Anthony P. Morrison et al., *Cognitive Therapy for the Prevention of Psychosis in People at Ultra-High Risk: A Randomised Controlled Trial*, 185 BRIT. J. PSYCHIATRY 291 (2004); Elizabeth A. Kuipers et al., *London-East Anglia Randomised Controlled Trial of Cognitive-Behavioural Therapy for Psychosis III: Follow-up and Economic Evaluations at 18 Months*, 173 BRIT. J. PSYCHIATRY 61 (1998). However, people who are already psychotic and not drug-resistant, the group in question here, are probably not likely to improve significantly with psychotherapy alone. See Gerald L. Klerman, *The Psychiatric Patient's Right to Effective Treatment: Implications of Osheroff v. Chestnut Lodge*, 147 AM. J. PSYCHIATRY 409 (1990).

77. One possible reform, yet to be adopted in any jurisdiction, is to permit trial of the unrestorably incompetent individual who, if convicted, would be committed to a mental hospital under the criteria applied to insanity acquittees. See CRIMINAL JUSTICE MENTAL HEALTH STANDARDS 7-4.13 (1984).

78. 406 U.S. 715, 738 (1972).

left—consisting of those who are properly treatable with medication but are allowed to refuse it because they are not dangerous, are competent to make treatment decisions, and can argue their right to refuse outweighs the government's interest in prosecution—will not be committable under traditional commitment criteria. If *Jackson* applies, these people—call them *Jackson*-eligible defendants—should be released.

Release probably makes sense for those *Jackson*-eligible defendants who are not charged with a serious crime. Many of these defendants should probably be diverted out of the criminal justice system in any event.⁷⁹ But release of individuals who are charged with a serious crime—here meaning any felony—may strike some as inappropriate, since the reason these defendants are not restorable is because of their refusal to take medication despite its medical appropriateness.⁸⁰ Furthermore, this refusal is presumably fully “knowing;” if these defendants were incompetent to make treatment decisions, they would have been forcibly medicated under the treatment incompetency exception.

Perhaps, as *Sell* suggests, *Jackson* should not apply to this latter category of competent, non-dangerous people. In the end, the choice will have to be made between, on the one hand, providing these people with the ability to game the system and, on the other, distorting commitment criteria so they will be deterred from doing so (the Court's “special circumstances”?). The only good news about this choice is that it will not have to occur very often, at least if all three exceptions discussed here are recognized.

IV. PROCEDURES

Sell raises numerous tough issues having to do with dangerousness, treatment incompetence, crime seriousness, and the effects of medication. In the prison context, *Harper* held that an administrative panel—consisting entirely of in-house employees, albeit employees who are “independent” of the treatment team—could make the initial decisions

79. This goal is arguably the whole point of mental health courts, which have proliferated recently. See, e.g., *Mental Health Courts Program*, DEP'T OF JUSTICE, https://www.bja.gov/ProgramDetails.aspx?Program_ID=68 (last visited Apr. 15, 2012) (“The goal of BJA's Mental Health Court grant program is to decrease the frequency of clients' contacts with the criminal justice system by providing courts with resources to improve clients' social functioning and link them to employment, housing, treatment, and support services.”).

80. Certainly *Jackson*'s commit-or-release rule for unrestorably incompetent defendants has met more than a little resistance. See Grant H. Morris & J. Reid Meloy, *Out of Mind? Out of Sight: The Uncivil Commitment of Permanently Incompetent Criminal Defendants*, 27 U.C. DAVIS L. REV. 1, 77–78 (1993) (as of 1993 a majority of jurisdictions ignore or circumvent *Jackson*).

about dangerousness and medication effects.⁸¹ In *Loughner*, however, the defense was successful on two different occasions in obtaining an injunction, pending a court hearing, challenging administrative decisions about treatment, principally on the ground that *Loughner* involved the pre-trial context rather than *Harper*'s post-conviction setting.⁸² In the March, 2012 three-judge decision in the *Loughner* case two of the judges, Bybee and Berzon, even signaled a willingness to require some sort of legal representation at these administrative hearings.⁸³ Further, as already noted, Berzon was insistent that re-commitment decisions that are contingent on whether forcible medication may occur require judicial review of any issue related to medication.⁸⁴

Sell did not address the procedural issues directly. However, in its discussion of why the dangerousness issue might be "more objective and manageable" than the competence restoration issue, the Court stated that

[M]edical experts may find it easier to provide an informed opinion about whether, given the risk of side effects, particular drugs are medically appropriate and necessary to control a patient's potentially dangerous behavior (or to avoid serious harm to the patient himself) than to try to balance harms and benefits related to the more quintessentially legal questions of trial fairness and competence.⁸⁵

This language resonates with Court language in other cases such as *Parham v. J. R.*⁸⁶ and *Vitek v. Jones*,⁸⁷ which approved relaxed procedural protections in treatment hearings. Court proceedings are expensive, are antithetical to the quick decision making often needed in treatment settings, and divert experts from their treatment chores.⁸⁸ Furthermore, a

81. *Washington v. Harper*, 494 U.S. 210, 234–35 (1990).

82. See *supra* text accompanying notes 25–37.

83. *United States v. Loughner*, Nos. 11-10339, 11-10504, 11-10432, 2012 WL 688805, at *25–29 n.6 (9th Cir. 2012) (Bybee, J.); *Id.* at *62–63 (Berzon, J.).

84. See *supra* text accompanying note 41.

85. *Sell v. United States*, 539 U.S. 166, 182 (2003).

86. 442 U.S. 584, 609 (1979) (upholding a process in which hospital staff presided over juvenile commitment, stating that "[c]ommon human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real.").

87. 445 U.S. 480, 496 (1980) (upholding a process in which hospital or prison staff approved a prison-to-hospital transfer).

88. See Alexander D. Brooks, *The Right to Refuse Antipsychotic Medication: Law and Policy*, 39 RUTGERS L. REV. 339 (1987) (detailing costs of judicial proceedings to the patient, the staff and the state).

defendant's dangerousness and competence can be very volatile.⁸⁹ Invoking a judicially supervised adversarial process every time a defendant's mental state fluctuates would be, at the least, highly inefficient and in some situations probably impossible.

The best argument for nonetheless involving a court in some way at the initial decision making stage is that, as the foregoing discussion suggested, *Sell* has created significant incentives for both the government officials and defense attorneys to manipulate the system. In other work I have put this point as follows:

[T]he decision [in *Sell*] creates an incentive for virtually all the players in the criminal process to act pretextually. . . [P]rosecutors may be prone to overcharge to make the government's interest more "important." Clinicians working at forensic facilities will be asked to treat "dangerousness" but will know the real purpose of the referral is to restore competency (and in those cases where the treatment modalities might differ depending on whether reduction in danger or restoration of competency is the goal, clinicians will be pressured to pursue both). Defense attorneys might be more likely to raise the competency issue even when competency is not in doubt, because a finding of incompetency and treatment refusal can lead to dismissal of charges. For the same reason, defendants will be tempted to refuse medication, even when they are not concerned about side effects, simply as a means of evading prosecution. In other words, everyone involved in criminal prosecution of a person who has been found incompetent will pretend restoration of competence is not the issue, when in fact it is the only issue.⁹⁰

A judge, with the benefit of a full adversarial hearing, will be better able to sniff out hidden agendas than hospital employees who, unconsciously or not, may be involved in the manipulation of the rules.

A compromise procedural framework might reconcile these two positions by fitting the decision maker to the decision to be made. The prosecution should have to state at the time a defendant is found incompetent whether it wants to invoke the serious crime exception. If it

89. Paul S. Appelbaum & Loren H. Roth, *Clinical Issues in the Assessment of Competency*, 138 AM. J. PSYCHIATRY 1462, 1464 (1981) ("Like the patient's mental status as a whole, a patient's competency may fluctuate as a function of the natural course of his or her illness, response to treatment, psychodynamic factors, . . . metabolic status, intercurrent illnesses, or the effect of medications.").

90. SLOBOGIN, *supra* note 54, at 229.

does, the court should decide whether the charge is in fact serious and whether the “special circumstances” caveat applies. Both of these are “quintessentially legal” issues. If the prosecution wins this argument and the defendant later refuses treatment the court then need only determine whether the *Riggins* criteria are met, a determination that will rely heavily on expert testimony. If the government is unable to convince the court that the serious crime exception governs and the defendant later refuses, an administrative panel should make the initial decision as to whether the dangerousness or incompetence exception applies, since these issues involve a mixture of clinical and legal issues and can be time-sensitive. However, as the policy upheld in *Harper* provided, these decisions would be subject to appeal to a court.

V. CONCLUSION

Sell raises many more questions than it answers. As the *Loughner* case illustrates, it also vastly increases the potential for the adversarial system simultaneously to harm the interests of both the defendant and society. The opinion is to be commended for reaffirming and emphasizing the *Riggins* requirements of medical appropriateness, efficacy and necessity. The drugs used to treat psychosis—including the so-called second-generation atypicals—all can have serious side effects, are frequently administered in unnecessarily large doses or are not good drugs for the particular person being treated, and are ineffective for anywhere from a quarter to a third of those to whom they are administered.⁹¹ In such cases, forcible medication (and perhaps even consensual medication) should not be permitted. But *Sell* goes beyond this clinically-beneficent restriction to suggest that even those who are safely restorable to competency through properly titrated medication have a right to refuse treatment aimed at achieving that goal, unless their crime is serious and prosecution is necessary to assure they are confined. Furthermore, to avoid the systemic impact of this holding, *Sell* tempts lower courts to implement a problematic dangerousness exception, while virtually ignoring the conceptually stronger but potentially rule-swallowing treatment-incompetency exception.

A much better approach—conceptually and practically—would be to enforce the *Riggins* criteria strictly, but to permit forcible medication to restore competency if those criteria are met, at least when felony charges

91. A good summary of the research supporting these points is found in BENTALL, *supra* note 47, at 222–24.

are involved. Under this approach, the conundrums embedded in the dangerousness, treatment incompetency, and serious crime exceptions would disappear, because they would no longer be relevant. Courts could then concentrate on ensuring that treatment efforts are directed at safely restoring defendants to a state where they can be fairly tried on their charges.