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The Costs of Delay: Incompetent Criminal Defendants, Involuntary Antipsychotic Medications, and the Question of Who Decides

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THE COSTS OF DELAY: INCOMPETENT CRIMINAL DEFENDANTS, INVOLUNTARY ANTIPSYCHOTIC MEDICATIONS, AND THE QUESTION OF WHO DECIDES

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INTRODUCTION

Jared Loughner was charged with killing six people and wounding thirteen others at an Arizona political event for Congresswoman Gabrielle Giffords, who was among those injured.[1] The resolution of the charges was on hold for more than a year because Loughner was not competent to stand trial.[2] Two medical experts diagnosed Loughner with schizophrenia, and the trial court concluded that Loughner's illness prevented him from rationally understanding the trial process.[3] The court placed Loughner in the custody of the Bureau of Prisons so that he could be rendered competent to stand trial. Loughner, though, refused the only treatment—antipsychotic medications—that was likely to alleviate his psychotic symptoms and make him competent to stand trial.[4]

The question whether the government could compel Loughner to take antipsychotic medications was considered by the federal district court in Arizona and the Ninth Circuit Court of Appeals several times.[5] After the Bureau of Prisons (BOP) medical personnel held an administrative hearing and determined that Loughner should be administered involuntary antipsychotic medications because of his dangerousness to himself and others, Loughner petitioned the district court for an order enjoining the BOP from administering involuntary medications to him.[6] Loughner claimed that the federal government's current regulatory scheme,[7]

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[1] Marc Lacey, *Suspect in Shooting of Giffords Ruled Unfit for Trial*, N.Y. TIMES, May 25, 2011, at A1, *available at* http://www.nytimes.com/2011/05/26/us/26loughner.html?pagewanted =all.

[2] Loughner recently pleaded guilty to nineteen charges. Fernanda Santos, *Life Term for Gunman After Guilty Plea in Tucson Killings*, N.Y. TIMES, Aug. 7, 2012, at A9, *available at* http://www.nytimes.com/2012/08/08/us/loughner-pleads-guilty-in-2011-tucson-shootings.html. Had he chosen to proceed to trial, it is possible that the resolution of the charges would have been delayed much longer. At the hearing where Loughner pleaded guilty, the court found that he was competent, but the possibility that he would not remain competent seems to have been a factor that motivated the prosecutor to pursue a guilty plea. *See id.* ("The volatility of Mr. Loughner's mental state was a deciding factor.").

[3] Lacey, *supra* note 1.

[4] Santos, *supra* note 2.

[5] *See* United States v. Loughner, No. 11–10339, 2011 WL 2694294 (9th Cir. July 12, 2011); *see generally Times Topics: Jared Lee Lougner*, N.Y. TIMES, Jan. 19, 2011, *available at* http://topics.nytimes.com/top/reference/timestopics/people/l/jared_lee_loughner/index.html?scp=1-spot&sq=jared%20loughner&st=cse (collecting articles related to Loughner's mental state and the question of involuntary medication).

[6] *Loughner*, 2011 WL 2694294.

[7] The specific regulation at issue was 28 C.F.R. § 549.43(a) (2003), which mandates the procedures to be followed "[w]hen an inmate is unwilling or unable to provide voluntary written informed consent for recommended psychiatric medication." The governing regulation is now found in 28 C.F.R. § 549.46(a) (2012).

which allows BOP medical personnel to decide to administer involuntary medications to pretrial detainees, violates the Due Process Clause.[8] The district court denied Loughner's motion but the Ninth Circuit Court of Appeals granted the motion and enjoined the BOP from administering involuntary medications to Loughner until the court could decide the merits of his due process claim.[9] Meanwhile, the district court allowed the BOP to administer involuntary antipsychotic medications to Loughner on an emergency basis.[10] The BOP continued to administer involuntary antipsychotic medications to Loughner throughout the eight months that the Ninth Circuit considered the merits of Loughner's argument that only a judge—and not BOP medical personnel—may authorize the administration of involuntary antipsychotic medications for the purpose of diminishing an incompetent pretrial detainee's dangerousness.[11] Eventually, the Ninth Circuit decided against Loughner, ruling that the administrative hearing conducted by BOP medical personnel to determine whether Loughner should be administered involuntary medications satisfied the requirements of the Due Process clause.[12]

Whether the constitutional guarantee of due process entitles an incompetent pretrial detainee to a judicial hearing before he may be administered involuntary antipsychotic medications to diminish his dangerousness is a question that arises at the intersection of two United States Supreme Court cases, *Washington v. Harper* and *Sell v. United States*.[13] In *Harper*, the Court ruled that a convicted prisoner is not entitled to a judicial hearing before he may be administered involuntary antipsychotic medications when the medications are necessary to diminish the prisoner's dangerousness to himself or others.[14] In *Sell*, the Court implied that an incompetent pretrial detainee is entitled to a judicial hearing before he may be administered involuntary antipsychotic medications, when the medications are necessary to render the detainee competent to stand trial.[15] Citing *Sell*, Loughner argued that as a pretrial detainee, he was entitled to a judicial determination while the government, citing *Harper*, argued that because medications were necessary to prevent Loughner from harming himself or others, he was not entitled to a judicial determination.[16]

This article argues that the decision whether to allow the government to administer involuntary antipsychotic medications should be made as quickly as possible, and for that reason,

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[8] *Loughner*, 2011 WL 2694294, at *1.

[9] *Id.* at *2.

[10] United States v. Loughner, 672 F.3d 731, 735 (9th Cir. 2012).

[11] *Id.* at 738.

[12] *Id.* at 756.

[13] Washington v. Harper, 494 U.S. 210 (1990); Sell v. United States, 539 U.S. 166 (2003).

[14] *Harper*, 494 U.S. at 231 ("Notwithstanding the risks that are involved, we conclude that an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge.").

[15] Although the question of who decides was not directly presented in *Sell*, the Court always refers to the decision-maker as "the court." *E.g.*, *Sell*, 539 U.S. at 180 (writing that "a court must find . . . ."); *id.* at 181 ("We emphasize that the court applying these standards . . . ."); *id.* at 183 ("If a court authorizes medication . . . .").

[16] *See* Appellant's Opening Brief at 44, United States v. Loughner, 2011 WL 2694294 (9th Cir. July 12, 2011) (No. 11–10339), 2011 WL 3204623 ("[I]n the course of discussing the advantages of starting with a dangerousness evaluation, *Sell* refers to 'a court' as the decision maker in this context no less than four times.") (citations omitted); Brief of Appellee at 13, United States v. Loughner, 2011 WL 2694294 (9th Cir. July 12, 2011) (No. 11–10339), 2011 WL 3529352 ("Contrary to the defendant's argument, *Harper* applies to pretrial detainees like him, as the district court noted, a conclusion fully supported by authority from the Supreme Court, this Court, and other circuits.").

medical personnel should decide.[17] Moreover, this article contends that the *Sell* Court's decision requiring a judicial hearing is ineffective in protecting those interests of detainees that the Court thought would be protected by a judicial hearing. Administering involuntary antipsychotic medications to a pretrial detainee does implicate interests that administering involuntary antipsychotic medications to a convicted prisoner does not—most importantly, the interest in receiving a fair trial. But given the nature of antipsychotic medications, requiring a judicial hearing on the question of involuntary antipsychotic medications is unlikely to protect the detainee's interest in a fair trial.[18] Furthermore, the delay involved in the judicial process harms the detainee's health and compromises the government's interest in rendering the detainee competent to stand trial.[19] Thus, mandating that only a judge may authorize involuntary antipsychotic medications costs both the detainee and the government, and benefits no one.

Part I of this article briefly reviews the Supreme Court's decision in *Sell v. United States*. The Court's intention in this case was good—to protect the fair trial rights of incompetent pretrial detainees. And the Court was certainly correct to be concerned about fair trial rights when a criminal defendant is being administered involuntary antipsychotic medications. As this Part explains, antipsychotic medications threaten the fairness of a criminal trial in several ways. But an apparent lack of understanding about the nature of antipsychotic medications caused the Court to adopt a rule that is ineffective. In most if not all cases, it is simply not possible to predict how a defendant will respond to antipsychotic medications so it is not possible to assess in advance whether those medications will undermine the fairness of the defendant's trial. Additionally, requiring a judicial hearing means that for a substantial amount of time, the detainee is not receiving treatment for a mental illness so severe that it has made him incompetent to stand trial. During this delay the defendant continues to suffer the symptoms of his illness without treatment, and untreated psychosis causes both immediate and long-term harms.

Part II of this article explains that there has been at least one judge who understood all of the pieces of this puzzle—the detainee's interest in receiving a fair trial, the government's interest in diminishing dangerousness and in adjudicating criminal charges, and the unpredictability of antipsychotic medications—and who proposed the solution that arguably protects all of these interests to the greatest extent possible. The judge is Emmett Sullivan of the D.C. District Court and the case was *United States v. Weston*.[20] The *Weston* case does differ from the Loughner case in that *Weston* was decided before *Sell*, and thus Judge Sullivan had to determine which, if either, of the government's interests—diminishing dangerousness or adjudicating criminal charges—could justify administering involuntary antipsychotic medications to an incompetent pretrial detainee. The interesting part of Judge Sullivan's decision for cases like *Loughner* is that Judge

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[17] The argument that medical personnel should decide does not mean, of course, that courts should not review these decisions on appeal. But the harms of untreated psychosis do suggest that courts should be somewhat hesitant to stay decisions authorizing involuntary antipsychotic medications pending appeal. For example, the Ninth Circuit arguably erred by not considering the harms of untreated psychosis in deciding to stay the district court's order authorizing the government to administer involuntary antipsychotic medications to Loughner. *See* United States v. Loughner, No. 11–10339, 2011 WL 2694294, at *2 (9th Cir. July 12, 2011) (failing to consider the harms of untreated psychosis in deciding to enjoin government from administering involuntary antipsychotic medications while appeal is pending).

[18] *See infra* Part II.

[19] *See infra* Part III.

[20] *See* United States v. Weston, 69 F. Supp. 2d 99 (D.D.C. 1999), *rev'd*, 206 F.3d 9 (D.C. Cir. 2000); *remanded to* United States v. Weston, 134 F. Supp. 2d 115 (D.D.C. 2001), *aff'd*, 255 F.3d 873 (D.C. Cir. 2001), *cert. denied*, 534 U.S. 1067 (2001).

Sullivan initially ruled that, in deciding whether the government could administer involuntary medications to Weston, there was no need yet to consider whether the medications would undermine the fairness of Weston's trial.[21] In short, Judge Sullivan said that while Weston remained incompetent to stand trial, the issue of trial rights was not ripe. The D.C. Circuit Court of Appeals disagreed, reversing and remanding for consideration of the trial rights issue before allowing the government to administer involuntary antipsychotic medications.[22] In the end, Judge Sullivan allowed involuntary antipsychotic medications after considering the issue of Weston's trial rights.[23] But by the time the appellate court finally agreed that Weston could be administered involuntary antipsychotic medications, he had spent three years in government custody—mostly in solitary confinement—without receiving any treatment for his psychotic symptoms.[24] When he finally was administered involuntary antipsychotic medications, he remained incompetent to stand trial even after more than two years of treatment.[25] Perhaps the medications would have been ineffective even if they had been administered to Weston sooner.[26] But *Weston* should nevertheless serve as a cautionary tale that delaying the treatment of psychotic symptoms can cost the defendant and the government a lot, without providing any benefit to anyone.

Part III discusses the need to amend the rule set out in *Sell* to more adequately protect the interests of incompetent pretrial detainees who are not dangerous to themselves or others, and who therefore may be administered involuntary medications only for the purpose of rendering them competent to stand trial. In *Loughner*, the Ninth Circuit decided, following *Harper*, that because the decision whether to administer involuntary medications is essentially a medical decision, the detainee's interests are adequately, and perhaps even optimally, protected by allowing the decision to be made by medical personnel. While this decision allows incompetent pretrial detainees who are dangerous to receive medications in a relatively timely manner, it does not help those detainees who are not dangerous. Under the present rule set forth in *Sell*, the decision whether to administer involuntary medications to a non-dangerous detainee can only be made by a judge, not by medical personnel. This Part proposes two alternate ways that this problem might be fixed. First, the Supreme Court could adopt a bright-line rule for determining which offenses are serious enough to justify the administration of involuntary medications for the purpose of rendering a detainee competent to stand trial. Second, trial courts could decide

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[21] United States v. Weston, 69 F. Supp. 2d 99, 107 (D.D.C. 1999) ("This Court holds that at this stage of the proceedings, where the defendant has not yet been arraigned and where there is no record evidence to suggest that the government's medical reasons are pretextual, the Due Process Clause requires the government to satisfy only the *Riggins* 'medically appropriate' standard.").

[22] United States v. Weston, 206 F.3d 9, 14 (D.C. Cir. 2000) (per curiam).

[23] United States v. Weston, 134 F. Supp. 2d 115, 138 (D.D.C. 2001).

[24] Douglas Mossman, *Is Prosecution "Medically Appropriate"?*, 31 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 15, 23 (2005) ("For the next three years, Weston remained at FCI-Butner except for times when he traveled to Washington DC for hearings; he spent much of his time in seclusion.").

[25] *Id.* at 27 (noting that Weston was administered involuntary antipsychotic medications for the purpose of rendering him competent to stand trial from January 2002 to mid-November 2004, when "Judge Sullivan ruled that Weston was unlikely to soon become competent and recommended that he be committed to a federal mental hospital, while leaving open the possibility that Weston could undergo trial for murder should he ever become competent.").

[26] A medical expert testifying for Weston predicted that the medications would be ineffective, given Weston's long history of untreated psychosis. *See* United States v. Weston, 134 F. Supp. 2d 115, 122 (D.D.C. 2001) (quoting Dr. Gur's explanation: "In light of the length of time (about two decades) that he has experienced delusions, the pervasiveness of his delusional system, lack of treatment, and the unfortunate fact that he has acted on his delusions, make it extremely unlikely that medication will eliminate or substantially attenuate his delusions.").

whether to grant medical personnel the authority to administer involuntary medications to particular incompetent criminal defendants at the same time as the trial courts authorize commitment for the purpose of rendering a defendant competent to stand trial. Either change would protect the defendant's liberty interest in refusing unwanted medical treatment, ensuring that involuntary medications are not administered unless the government has a sufficiently important interest to justify the medications. Additionally, either change would reduce the damage, to both the defendant's and the government's interests, that results from leaving incompetent detainees to experience extended periods of untreated psychosis.

I. THE PROBLEM

A criminal defendant who is not competent to stand trial because of psychotic symptoms,[27] and who refuses to take voluntarily the antipsychotic medications that might make him competent, raises several important and complex questions about when the government may administer these medications over the defendant's objection. Fundamentally, everyone has a right to refuse unwanted medical treatment but that right may be overridden by a sufficiently important government interest.[28] In *Sell v. United States*, the Supreme Court ruled that the government's interest in adjudicating criminal charges can sometimes—and perhaps even most times, although probably not all of the time (the Court was not especially clear about this)—justify administering involuntary antipsychotic medications to a defendant who is incompetent to stand trial.[29] Additionally, the Constitution guarantees a criminal defendant a long list of trial-related rights, including the rights to confront the witnesses against him, to call witnesses in his favor, to have the assistance of counsel, and to either testify on his own behalf or to remain silent.[30] While antipsychotic medications might render a defendant competent to stand trial, these medications might also undermine the fairness of his trial by compromising his ability to exercise his constitutional trial rights.

The *Sell* Court acknowledged that "antipsychotic drugs might have side effects that would interfere with the defendant's ability to receive a fair trial"[31] and ruled that even when the government has an important interest in bringing a defendant to trial, the government may not administer involuntary antipsychotic medications unless the court finds that these medications are "substantially unlikely to have side effects that will interfere significantly with the defendant's

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[27] Defendants may be incompetent to stand trial for reasons other than psychotic symptoms; those cases are beyond the scope of this article.

[28] *See* Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 262 (1990) (holding that "the question whether [the right to refuse unwanted medical treatment] has been violated must be determined by balancing the liberty interest against relevant state interests"); *see also* Jacobson v. Massachusetts, 197 U.S. 11, 24-30 (1905) (holding that the government's interest in public health is sufficient to justify mandatory vaccinations).

[29] The *Sell* Court instructed that one factor for trial courts to consider in deciding whether to allow involuntary medications is the importance of the government's interest in adjudicating the charges against the defendant, but the Court provided little guidance about how trial courts should assess importance. *See* Sell v. United States, 539 U.S. 166, 180 (2003) ("First, a court must find that *important* governmental interests are at stake. The Government's interest in bringing to trial an individual accused of a serious crime is important. That is so whether the offense is a serious crime against the person or a serious crime against property.") (italics in original).

[30] *See* U.S. CONST. amends. V, VI.

[31] Sell v. United States, 539 U.S. 166, 179 (2003).

ability to assist counsel in conducting a trial defense, thereby rendering the trial unfair."[32]

A more comprehensive discussion of the issue of fair trial rights and antipsychotic medication effects is found in Justice Kennedy's concurring opinion in an earlier case, *Riggins v. Nevada*.[33] Prior to his trial on charges of robbery and murder, David Riggins had asked the trial court to discontinue the antipsychotic medications that the state was administering to him.[34] The court refused, without explanation, and thus Riggins was administered involuntary antipsychotic medications during his trial.[35] After he was convicted, he appealed the trial court's decision denying his request to discontinue the mediations, claiming that because of the effects and side effects of the medications, he had been denied a fair trial. The Supreme Court in *Riggins* acknowledged that the medications might have affected the fairness of Riggins's trial,[36] but the Court based its decision reversing the conviction primarily on the failure of the trial court to consider whether the state of Nevada had any interest that might have justified administering involuntary antipsychotic medications to Riggins during his trial.[37]

In a concurring opinion, Justice Kennedy took up the issue of the impact of antipsychotic medications on the fairness of a criminal trial. He outlined several ways that antipsychotic medications can undermine a criminal trial's fairness. First, Justice Kennedy observed both that the defendant's demeanor can influence the outcome of a criminal trial and also that antipsychotic medications can profoundly affect a defendant's demeanor.[38] If antipsychotic medications cause a defendant to experience motor tremors, for example, the jury might misinterpret the tremors as a sign of nervousness and guilt. Or the tremors might cause the defendant to be inattentive or unresponsive to the trial proceedings, which the jury might misinterpret as cold-hearted lack of remorse. Justice Kennedy also observed that antipsychotic medications can interfere with a defendant's relationship with counsel.[39] A defendant who is anxious or sedated because of antipsychotic medications might have difficulty communicating with his attorney. And similarly, the defendant—should he choose to take the stand and testify in his own defense—might have difficulty presenting his story to the jury.[40] By prejudicing his demeanor, and interfering with his rights to have the assistance of counsel and to testify on his own behalf, antipsychotic medications threaten the fairness of the defendant's trial.

In *Sell*, the Court relied on Justice Kennedy's concurring opinion in ruling that, before allowing the government to administer involuntary antipsychotic medications, trial courts must determine that these medications are "substantially unlikely to have side effects that will interfere

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[32] *Id.* at 179.

[33] Riggins v. Nevada, 504 U.S. 127, 139–46 (1992) (Kennedy, J., concurring).

[34] *Id.* at 129.

[35] *Id.* at 131 ("The District Court denied Riggins' motion to terminate medication with a one-page order that gave no indication of the court's rationale. Riggins continued to receive 800 milligrams of Mellaril each day through the completion of his trial the following November.") (citation omitted).

[36] *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.").

[37] *Id.* at 138 ("Because the record contains no finding that might support a conclusion that administration of antipsychotic medication was necessary to accomplish an essential state policy . . . we have no basis for saying that the substantial probability of trial prejudice in this case was justified.").

[38] *Id.* at 142-44 (Kennedy, J., concurring).

[39] *Id.* at 144-45.

[40] *Id.* at 145-46.

significantly with the defendant's ability to assist counsel in conducting a trial defense."[41] But *Riggins* was a retrospective case—by the time the Court was considering the issue of antipsychotic medications and trial rights, Riggins's trial was over. The Court did observe that it would be difficult to determine from the record whether the antipsychotic medications had caused Riggins to experience any side effects that compromised the fairness of his trial.[42] But quite logically—because the case did not present the issue—the Court did not also say that it would have been difficult for the trial court to have predicted whether Riggins would experience any side effects that would compromise the fairness of his trial. *Sell*, however, was a prospective case, and thus the Court should have recognized the futility of requiring a judge to determine, in advance of allowing involuntary medications, whether the defendant will experience side effects that will undermine the fairness of the defendant's trial.

It is a well-documented fact that it is generally not possible to predict how a particular person will respond to a particular antipsychotic medication.[43] For treating physicians, this means that finding a medication that is effective in alleviating the symptoms of psychosis but does not cause side effects that are intolerable is an exercise in trial and error. For courts, this means that under *Sell*, determining whether side effects will undermine the fairness of a criminal trial comes down to a question of statistics—what percentages of people who take a particular medication experience various side effects? But of course, this is not an individualized assessment; the Supreme Court might as well have ruled in *Sell* that antipsychotic medications are statistically unlikely to cause side effects that will undermine the fairness of a trial and spared all of the trial judges who consider this question from having to reach that very conclusion anew in each case they consider.[44]

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[41] Sell v. United States, 539 U.S. 166, 181 (2003) (citing Riggins v. Nevada, 504 U.S. 127, 142–145 (1992) (Kennedy, J., concurring).

[42] Riggins v. Nevada, 504 U.S. 127, 137 (1992) ("Efforts to prove or disprove actual prejudice from the record before us would be futile, and guesses whether the outcome of the trial might have been different if Riggins' motion had been granted would be purely speculative.").

[43] RALPH REISNER ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 27-28 (4th ed. 2004) ("The neuroleptic of choice for any given patient must be determined to a considerable degree by trial and error."); William M. Brooks, *Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs*, 31 IND. L. REV. 937, 946 (1998) ("Physicians must prescribe antipsychotic drugs on a trial and error basis as there is no accurate method of determining how a patient will respond to a particular drug."); Anna C. Need et al., *Pharmacogenetics of antipsychotic response in the CATIE trial: a candidate gene analysis*, 17 EUR. J. HUM. GENETICS 946, 946-47 (2009) ("[O]ur capacity to predict therapeutic response and clinically significant side effects in individual patients is currently extremely limited. There are, for example, no effective means by which to match individual patients to medications that offer them more symptom control or that reduce their chances or severity of adverse reactions."); United States v. Ruiz-Gaxiola, 623 F.3d 684, 699 n.10 (9th Cir. 2010) ("The FMC-Butner Evaluation noted that '[r]esponse to antipsychotic medication is highly individual,' and explained that '[b]ecause it is difficult to predict an individual's response to antipsychotic medication, [the APA statistics] have been provided to indicate the likelihood of response if an individual is treated with an antipsychotic medication.'").

[44] For recent examples of how courts assess how likely it is that antipsychotic medications will cause side effects that make a defendant's trial unfair, see United States v. Diaz, 630 F.3d 1314, 1326 (11th Cir. 2011) ("Dr. Sarrazin's report noted that, based on the statistical data, Diaz would be unlikely to experience the delayed neuromuscular side effects of tardive dyskinesia or tardive dystonia if treated for a year with either a first- or second-generation medication . . ."); United States v. Muhammad, No. 07-737-04, 2010 WL 2533777, at *10 (E.D. Pa. 2010) ("Side effects occur in up to thirty (30) percent of patients on antipsychotics."); United States v. Steward, No. 06-864-MRH, 2009 WL 4839529, at *2 (C.D. Cal. 2009) ("Possible side effects of Risperdal include tardive dyskinesia (involuntary muscle movement) in sensitive individuals taking high doses, low blood pressure and associated fainting in one to five percent of

II. A BETTER THOUGH NOT PERFECT APPROACH

Russell Weston was charged with the murder of two federal police officers and the attempted murder of a third officer.[45] Weston shot the officers as they tried to prevent him from entering the U.S. Capitol building; Weston believed that he could save the world from a deadly plague if he could access the secret time machine located in the basement of the building.[46] The trial court promptly found that because of psychotic symptoms, Weston was not competent to stand trial.[47] Weston, though, refused to take antipsychotic medications voluntarily. The government sought to administer involuntary antipsychotic medications to Weston for two purposes: to diminish Weston's dangerousness and to render Weston competent to stand trial.[48]

In its first ruling, the district court decided that the only issue that was ripe was whether the government could administer involuntary medications for the purpose of diminishing Weston's dangerousness.[49] The court decided that because Weston could be administered involuntary antipsychotic medications for the purpose of diminishing his dangerousness, the court did not need to decide whether Weston could be administered involuntary antipsychotic medications for the purpose of rendering him competent to stand trial.[50] The court also postponed considering the question whether involuntary antipsychotic medications would undermine the fairness of Weston's trial, reasoning that a trial would only be possible if the medications rendered Weston competent, an outcome that was not guaranteed. So the court decided to cross the fair-trial-rights bridge when it came to it: "In the event that medication successfully renders the defendant competent to stand trial, the court could then reach the defendant's argument that the Due Process Clause or the Sixth Amendment will require a heightened showing before the defendant may be forcibly medicated during the trial."[51]

The D.C. Circuit Court of Appeals reversed, ruling that the fair-trial-rights issue was indeed ripe even though Weston might never become competent to stand trial.[52] The appeals

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patients, arrhythmia in less than one half of one percent of patients, tiredness, dizziness and slowed mental functioning at very high doses."); United States v. Moruzin, 583 F. Supp. 2d 535, 543 (D.N.J. 2008) ("Dr. Lucking acknowledged that the literature reports that as many as fifty percent of patients who take Haldol experience pseudo-Parkinson's-type side effects, but testified that in his practice, he observed such effects at a rate as low as ten percent.").

An exception to this inability to make individualized predictions might possibly exist if a defendant has taken antipsychotic medications in the past and can report what the medications' effects were. But having information about how someone has responded to antipsychotic medications in the past does not mean that a decision-maker necessarily knows how that person will respond in the present, because responsiveness varies not only across individuals but also within individuals over time.

45 United States v. Weston, 69 F. Supp. 2d 99, 102 (D.D.C. 1999).

46 United States v. Weston, 206 F.3d 9, 19-20 (D.C. Cir. 2000) (Tatel, J., concurring).

47 *Weston*, 69 F. Supp. 2d at 99.

48 *Id.* at 118.

49 *Id.* at 101.

50 *Id.* at 119 ("[I]f treatment is justified on dangerous grounds, the Court need not reach the issue whether the defendant may be treated solely to render him competent to stand trial. Thus, this Court need not reach this collateral issue at this time.").

51 *Id.* at 107.

52 United States v. Weston, 206 F.3d 9, 14 (D.C. Cir. 2000) (per curiam) (asserting that "both the defendant, whose right to present a defense may be infringed by involuntary medication, and the government, whose eventual prosecution of the defendant may be foreclosed because of the infringement, are entitled to pre-medication resolution of

court explained that "because antipsychotic medication may affect the defendant's ability to assist in his defense . . . post-medication review may come too late to prevent impairment of his Sixth Amendment right."[53] It is hard to criticize the court when it appears to be choosing to err on the side of ensuring that the defendant receives a fair trial. On the other hand, the appeals court seemed to think that there were two and only two possible points at which the trial court could consider the defendant's claim that involuntary medications would undermine the fairness of his trial: before the medications have been administered and after the defendant has been tried.[54] But there are other possibilities, including the possibility that the trial court seemed to have in mind in this case: after medications have been administered but before the defendant's trial has begun.

To be sure, there are problems with evaluating the effects of involuntary antipsychotic medications on a defendant's ability to exercise his fair trial rights after medications have been administered but before the defendant's trial has begun. Most significantly, there is no good baseline for determining whether any impairments that a medicated defendant is experiencing are caused by the medication. For example, a medicated defendant might have trouble concentrating, or might appear agitated or aloof, but these impairments might or might not be caused by medication. Despite this difficulty, postponing the inquiry about fair trial rights until after medications have been administered and after the defendant has become competent to stand trial offers two important advantages compared to the present system, with its months if not years of judicial hearings, rulings, appeals and reversals, all while the defendant remains incompetent to stand trial. The first advantage is that once the defendant has been medicated and has become

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the Sixth Amendment issue"). The appeals court also ruled that because Weston was not dangerous while in seclusion, involuntary medication was not justified by the need to diminish Weston's dangerousness:

> [W]hat evidence there is indicates that in his current circumstances Weston poses no significant danger to himself or to others. Dr. Johnson herself testified at the August 20, 1999 hearing that, given Weston's "immediate containment situation," she felt confident the Butner staff "can prevent him from harming himself or others under his immediate parameters of incarceration where he is in an individual room with limited access to anything that he could harm himself with or anyone else with, and he remains under constant observation."

Id. at 13. This is a terrible ruling, which the appeals court seemed to recognize as terrible in its next decision in the *Weston* case. *See* United States v. Weston, 255 F.3d 873, 888 (D.C. Cir. 2001) (Randolph, J., concurring) ("[T]he question on Weston's first appeal should not have been whether he was dangerous given the manner in which he was confined, but whether he was dangerous as a general matter, that is, if he were released from strict confinement and observation."). The Ninth Circuit Court of Appeals came close to making this same mistake: "The government's interest is . . . less immediate. It has managed to keep Loughner in custody for over six months without injury to anyone. We are confident it can continue to do so for the short period it will take to resolve this appeal on the merits." United States v. Loughner, No. 11–10339, 2011 WL 2694294, at *2 (9th Cir. July 12, 2011).

[53] *Weston*, 206 F.3d at 14 (per curiam).

[54] Judge Tatel, writing in a separate concurring opinion, did acknowledge the problem with requiring a pre-medication assessment of medication effects, and seemed to accept the option that Judge Sullivan had chosen:

> [T]he difficulty inherent in predicting how a particular drug will affect a particular individual may well lead the district court to conclude that it cannot make this determination about Weston without first medicating him. In that event, I see no reason why the potential for side effects would preclude the district court from ordering medication, provided that, should Weston become competent to stand trial, the district court conducts a second hearing to determine the extent to which any side effects Weston is actually experiencing might affect his fair trial rights.

Id. at 21 (Tatel, J., concurring).

competent to stand trial, even if there is uncertainty about whether medication effects will compromise a defendant's trial rights, the defendant is at least in a position to decide whether to proceed to trial or to plead guilty—a position that is arguably better than his position prior to medication, when he was subject to indeterminate and possibly indefinite civil commitment.[55] The second advantage is that all of the judicial hearings, rulings, appeals and reversals are avoided, and the decision whether to administer involuntary medications can be made relatively quickly, preventing the defendant from experiencing an extended period of untreated psychosis.

The delay involved in a judicial determination of the appropriateness of administering involuntary antipsychotic medications does not advance anyone's legal interests—not the prosecutor's interest in bringing the defendant to trial and not the defendant's interest in receiving a fair trial. The prosecutor's interest is not advanced because delay diminishes the likelihood that medications, when they are eventually administered, will effectively alleviate the defendant's psychotic symptoms. And the defendant's interest is not advanced because whether medications will undermine a trial's fairness cannot be determined until the defendant's response to the medications can be observed. Moreover, the delay prevents the defendant from receiving timely treatment for what has been called "the worst disease affecting mankind."[56]

Schizophrenia is classified as a formal thought disorder, because "[d]isorganized thinking ('formal thought disorder') has been argued by some to be the single most important feature of Schizophrenia."[57] However, schizophrenia is actually a whole mind disorder, disrupting every aspect of psychological functioning. According to the American Psychiatric Association, "[t]he characteristic symptoms of Schizophrenia involve a range of cognitive and emotional dysfunctions that include perception, inferential thinking, language and communication, behavioral monitoring, affect, fluency and productivity of thought and speech, hedonic capacity, volition and drive, and attention."[58]

The treatment that is most effective in alleviating active psychotic symptoms is antipsychotic medications.[59] Other treatments are important in the long-term management of the disorder but for someone who is acutely psychotic, no other kind of biological therapy and no psychosocial therapy is likely to diminish the psychosis.[60]

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[55] *See* Lisa Kim Anh Nguyen, *Punishment and Crime: In Defense of* Sell*: Involuntary Medication and the Permanently Incompetent Criminal Defendant*, 2005 U. CHI. LEGAL F. 597, 623 (2005) ("[F]orcible medication allows the defendant to proceed to trial and exercise his rights guaranteed by the Constitution. Consequently, the ability to stand trial, even under forcible medication, provides greater constitutional protections than the indeterminate state attendant upon incompetency.").

[56] *Where Next with Psychiatric Illness?*, 336 NATURE 95, 95 (1988).

[57] AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 300 (4th ed. text rev. 2000).

[58] *Id. at* 299.

[59] *See* John M. Kane, *Conventional Neuroleptic Treatment: Current Status, Future Role*, in THE NEW PHARMACOTHERAPY OF SCHIZOPHRENIA 89, 90 (Alan Breier ed., 1996) (describing antipsychotic medications as "the primary modality in the treatment of an acute episode or an acute exacerbation of a schizophrenic illness"); Thomas H. McGlashan, *Rationale and Parameters for Medication-Free Research in Psychosis*, 32 SCHIZOPHRENIA BULL. 300, 301 (2006) (noting that antipsychotic medications are "the most rapid, effective, and economical treatment for active psychosis").

[60] *See* PATRICK W. CORRIGAN ET AL., PRINCIPLES AND PRACTICE OF PSYCHIATRIC REHABILITATION: AN EMPIRICAL APPROACH 60 (2008) ("The current view in psychiatry is that psychotropic medications are a critical component of treatment, but that provision of medications in the absence of psychosocial interventions is insufficient."); T. SCOTT STROUP ET AL., ESSENTIALS OF SCHIZOPHRENIA 173-74 (Jeffrey A. Lieberman et. al. eds., 2012) (noting that

The immediate experience of untreated psychosis is bad enough.[61] But there is also evidence that untreated psychosis causes lasting damage, diminishing future responsiveness to antipsychotic medications.[62] Requiring a judicial ruling before administering involuntary medications to an incompetent pretrial detainee leaves the detainee—often for months and sometimes for years—in a state of untreated psychosis. During this time the detainee is simply warehoused in a psychotic state.[63] If this delay were important for protecting the detainee's fair trial rights, then we might ask whether the benefits are worth the costs. But there is no benefit that the defendant receives in exchange for these costs, because requiring a judge to predict whether involuntary antipsychotic medications will cause a defendant's trial to be unfair is an exercise in futility—or at best, an exercise in the application of statistical data.[64]

"[a]ntipsychotic drugs are commonly and effectively used to treat positive symptoms, such as hallucinations, delusions, and disorganized speech and behavior" while "[a]nxiolytics, antidepressants, and mood-stabilizing drugs are often used as adjunctive treatments for mood symptoms").

Loughner proposed that to diminish his dangerousness, the government should consider placing him in restraints or seclusion as a "less intrusive alternative" to involuntary antipsychotic medications. *See* Appellant's Opening Brief at 12, United States v. Loughner, 2011 WL 2694294 (9th Cir. Aug. 15, 2011) (No. 11-10339), 2011 WL 3204623 ("Here, 'less intrusive' means of mitigating danger—use of minor tranquilizers, isolation, or, if necessary, restraints—were available."). Placing someone who is actively psychotic in restraints or seclusion is not only non-therapeutic, it is anti-therapeutic. *See* William A. Fisher, *Restraint and Seclusion: A Review of the Literature*, 151 AM. J. PSYCH. 1584, 1588 (1994) (concluding that "although it appears to be reasonably well-established that seclusion and restraint 'work,' i.e., they provide an effective means for preventing injury and reducing agitation, it is at least equally well-established that these procedures can have serious deleterious physical and (more often) psychological effects on patients."). Loughner also suggested that other medications, such as "minor tranquilizers," should be administered. Appellant's Opening Brief at 12, United States v. Loughner, 2011 WL 2694294 (9th Cir. Aug. 15, 2011) (No. 11-10339), 2011 WL 3204623. But while such drugs would sedate someone with schizophrenia, just as they would sedate someone who does not have schizophrenia, tranquilizers do not diminish psychosis and thus, if Loughner is dangerous because of psychotic symptoms, tranquilizers would be nothing more than chemical restraints. In Washington v. Harper, the Supreme Court addressed the possibility that antipsychotic medications would be administered to prison inmates for an inappropriate purpose, such as behavior control or punishment, noting that "[t]he drugs may be administered for no purpose other than treatment . . . ." 494 U.S. 210, 226 (1990). More recently, the issue of using antipsychotic medications to chemically restrain juveniles or residents of nursing homes has received scholarly attention. *See, e.g.*, Ashley A. Norton, Note, *The Captive Mind: Antipsychotics as Chemical Restraint in Juvenile Detention*, 29 J. CONTEMP. HEALTH L. & POL'Y 152, 166 (2012) ("According to the American Association of Child and Adolescent Psychiatry (AACAP), 'chemical restraint' of a child is the use of a drug without a therapeutic purpose and with the sole purpose of sedating and immobilizing the child."); Cory W. Brooks, Note, *Skilled Nursing Homes: Replacing Patient Restraints with Patient Rights*, 45 S.D. L. REV. 606, 617 (2000) ("A chemical restraint is an antipsychotic medication administered to sedate unruly residents, induce sleep, and to control behaviors often associated with dementia.").

[61] One leading schizophrenia researcher has described active psychosis this way: "Active psychosis is a dangerous, life-threatening state. Behavior is often unpredictable because of misperceptions, misconceptions, and irrational thinking. The gravest dangers are suicide, homicide, and physical injury." Thomas H. McGlashan, *Rationale and Parameters for Medication-Free Research in Psychosis*, 32 SCHIZOPHRENIA BULL. 300, 300 (2006).

[62] *See* T. SCOTT STROUP ET AL., ESSENTIALS OF SCHIZOPHRENIA 197 (Jeffrey A. Lieberman et. al. eds., 2012) (noting that "a delay in treatment of the first episode of schizophrenia and in the treatment of acute exacerbations is associated with poorer clinical outcomes") (citations omitted); Thomas H. McGlashan, *Schizophrenia in Translation: Is Active Psychosis Neurotoxic?*, 32 SCHIZOPHRENIA BULL. 609, 612 (2006) ("If prolonged, [active psychosis] may well create deficits that add to severity beyond the level ultimately determined by the original brain pathophysiology.").

[63] *See* United States v. Weston, 134 F.Supp.2d 115, 130 (D.D.C. 2001) (observing that confinement without treatment is "simply the warehousing of Weston in a psychotic state").

[64] *See supra* note 44.

III. TWO SOLUTIONS

In *Loughner*, the Ninth Circuit Court of Appeals concluded that being dangerous because of a mental illness is more important than being incompetent to stand trial because of a mental illness, and thus *Harper* rather than *Sell* establishes the proper substantive and procedural standards for determining whether Loughner may be administered involuntary medications.[65] The Court further concluded that the decision of BOP medical personnel, made after an administrative hearing, adequately protected Loughner's Due Process rights.[66]

This is arguably the right result because it minimizes the time that a detainee is left in the midst of an episode of untreated psychosis that should be treated despite the detainee's refusal of treatment. Minimizing the duration of untreated psychosis, though, was not the rationale that the *Loughner* court offered to explain its ruling. Instead, the court not only adopted *Harper*'s standards but also embraced *Harper*'s rationale that "an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge."[67] What is unsatisfying about the *Loughner* court adopting *Harper's* rationale is that the rationale applies equally to incompetent pretrial detainees who are not dangerous because of a mental illness. If any government interest justifies administering involuntary medications to a detainee who is incompetent to stand trial because of a mental illness, the detainee's interests—as well as the government's—are best served by allowing the decision to medicate to be made by medical professionals rather than a judge.

The only relevant difference between a detainee who is medicated for the purpose of diminishing dangerousness and a detainee who is medicated for the purpose of establishing competence to stand trial is the question whether the government has an important enough interest at stake to justify overriding the detainee's liberty interest in refusing unwanted medical treatment.[68] When the detainee is dangerous to himself or others, the government has an interest in diminishing dangerousness that justifies the administration of involuntary medications.[69] But when the detainee is not dangerous, it is the government's interest in rendering the detainee competent to stand trial that can justify involuntary medications.[70] Under *Sell*, courts must

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[65] *See* United States v. Loughner, 672 F.3d 731, 752 (9th Cir. 2012) ("[W]e now hold that when the government seeks to medicate a detainee—whether pretrial or post-conviction—on the grounds that he is a danger to himself or others, the government must satisfy the standard set forth in *Harper*.").

[66] *See Loughner*, 672 F.3d at 756 ("[T]he Due Process Clause does not require a judicial determination or a judicial hearing before a facility authorizes involuntary medication.").

[67] *Id.* at 754 (quoting Washington v. Harper, 494 U.S. 210, 231 (1990)).

[68] Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 278 (1990) ("The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.").

[69] *See*, *e.g.*, Bee v. Greaves, 744 F.2d 1387, 1394 (10th Cir. 1984); Rennie v. Klein, 720 F.2d 266, 269 (3d Cir. 1983) (en banc); Rogers v. Okin, 634 F.2d 650, 656-57 (1st Cir. 1980); Project Release v. Prevost, 551 F.Supp. 1298, 1309 (E.D.N.Y. 1982), *aff'd*, 722 F.2d 960 (2d Cir.1983); Davis v. Hubbard, 506 F.Supp. 915, 934-38 (N.D. Ohio 1980); People v. Medina, 705 P.2d 961, 973-74 (Colo. 1985) (en banc); Rogers v. Commissioner, 458 N.E.2d 308, 319-22 (Mass. 1983); Rivers v. Katz, 495 N.E. 2d 337, 343 (N.Y. 1986).

[70] Prior to *Sell*, whether the government's interest in rendering a defendant competent to stand trial could justify administering involuntary medications was not at all certain. *Compare* United States v. Weston, 255 F.3d 873, 876 (D.C. Cir. 2001) (allowing involuntary medication solely for the purpose of rendering the detainee competent to stand trial) *and* Khiem v. United States, 612 A.2d 160, 168-69 (D.C. 1992) (as amended on rehearing) (same) *with* Woodland v. Angus, 820 F. Supp. 1497, 1511-12 (D. Utah 1993) (ruling that the government's interest in rendering the detainee

answer, on a case-by-case basis, the question whether the government's interest in bringing a detainee to trial is important enough to justify involuntary medications.[71]

There are two ways to fix *Sell*'s problem and allow the decision whether to administer involuntary antipsychotic medications to an incompetent pretrial detainee to be made by medical personnel even when the detainee is not dangerous and only the government's interest in bringing the detainee to trial can justify involuntary medications. Under *Sell*, administering involuntary medications for the purpose of rendering a criminal defendant competent to stand trial requires that: the government have an "important" interest at stake, which means that the defendant has been charged with a "serious" offense; the medications are substantially likely to render the defendant competent without compromising the defendant's trial rights; there is no less intrusive means of achieving the government's interests; and the medications are in the defendant's medical interests.[72] Only the first factor, the importance of the government's interest, is primarily a legal question. The remaining three factors are primarily if not exclusively medical questions and thus there is no reason why they should not be left to medical personnel to evaluate. Thus, the entire question whether to administer involuntary medications could be turned over to medical personnel if the trial court did not need to make a separate, case-by-case assessment of the importance of the government's interest. *Sell*'s problem could be fixed either by having bright-line rules for assessing the importance of the government's interest or by having the trial court make an individualized assessment at the time that the defendant is committed for the purpose of making him competent to stand trial. Either of these changes would enable medical personnel to make the decision whether to administer involuntary medications to an incompetent pretrial detainee in a relatively timely manner without compromising the defendant's interest in refusing unwanted medical treatment absent a sufficiently important government interest.

A. A Bright-Line Rule of Offense Seriousness

To enable medical personnel to make the decision whether to administer involuntary medications to an incompetent pretrial detainee for the purpose of making him competent to stand trial, the Supreme Court could adopt a bright-line rule for assessing the importance of the government's interest in bringing a criminal defendant to trial. As some courts have already recognized in applying *Sell*, such bright-line tests of importance already exist in similar contexts. For example, offenses punishable by imprisonment of more than six months are considered

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competent to stand trial did not justify involuntary medications) *and* United States v. Santonio, No. 2:00-CR-90C, 2001 WL 670932, at *6 (D. Utah May 3, 2001) (same).

[71] Sell v. United States, 539 U.S. 166, 180 (2003) ("First, a court must find that *important* governmental interests are at stake.") (italics in original).

[72] *Id.* at 179. As the Court summarized the *Sell* test:

> [T]he Constitution permits the Government involuntarily to administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial, but only if 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.

Id. The Court also explained that the importance of the government's interest is a function of the seriousness of the charges against the defendant; a court must find that important governmental interests are at stake. "The Government's interest in bringing to trial an individual accused of a serious crime is important." *Id.* at 180.

serious for purposes of the Sixth Amendment right to trial by jury;[73] the Fourth Circuit has applied this rule in *Sell* cases.[74] Other courts have used different measures, such as the maximum statutory penalty for the offense charged[75] or the projected penalty under sentencing guidelines.[76] Of these, the maximum statutory penalty for the offenses charged would arguably be the most appropriate substantively,[77] as well as fairly straightforward to apply. It is also the one that most courts have chosen to apply.[78]

One problem with adopting a bright-line rule of offense seriousness is that the *Sell* Court advised that there might be certain factors, such as the availability of civil commitment as an alternative to prosecution and the amount to time a defendant has already been in custody, that in individual cases might offset the seriousness of the charged offenses and cause the government's interest in bringing a defendant to trial to be not important enough to justify involuntary medications.[79]

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[73] *See* Duncan v. Louisiana, 391 U.S. 145, 154 (1968) (incorporating the right to trial by jury for "serious" crimes); *see also* Baldwin v. New York, 399 U.S. 66, 68-69 (1970) (plurality opinion) (clarifying *Duncan* by holding that crimes punishable by imprisonment of more than six months are "serious" for purposes of the right to trial by jury).

[74] *See* United States v. Evans, 293 F. Supp. 2d 668, 674 (W.D. Va. 2003) (ruling that a serious crime is one that carries a maximum sentence of more than six months imprisonment). Other courts have rejected this standard as inappropriate, given that it derives from the rule regarding jury trials—a rule intended to protect criminal defendants' interests—while the assessment of the seriousness of the charges against the defendant as required under *Sell* is about the government's interest. *See Developments in the Law—The Law of Mental Illness:* Sell v. United States: *Forcibly Medicating the Mentally Ill to Stand Trial*, 121 HARV. L. REV. 1121, 1127 (2007-2008) [hereinafter *Forcibly Medicating*] ("While the sentence length is a reasonable consideration for determining whether a defendant-protective right should apply, it is a less useful signal of whether there is a serious state interest in seeing a defendant brought to trial.").

[75] *See* United States v. Green, 532 F.3d 538, 549 (6th Cir. 2008) ("[T]he maximum statutory penalty is the most objective means of determining the seriousness of a crime and the standard we adopt."); United States v. Evans, 404 F.3d 227, 237 (4th Cir. 2005) ("[I]t is appropriate to focus on the maximum penalty authorized by statute in determining if a crime is 'serious' for involuntary medication purposes."). As the Sixth Circuit noted, the Supreme Court has endorsed this approach on several occasions. *Green*, 532 F.3d at 549 ("Moreover, the Supreme Court has spoken on this very point in other jurisprudence. Whether a crime is 'serious' should be determined by its maximum statutory penalty.") (citing Lewis v. United States, 518 U.S. 322, 326 (1996) and Blanton v. City of North Las Vegas, 489 U.S. 538, 541-542 (1989)).

[76] United States v. Hernandez-Vasquez, 513 F.3d 908, 919 (9th Cir. 2008) (deciding that "the likely guideline range is the appropriate starting point"). Other courts have rejected this standard as impractical. *See*, *e.g.*, United States v. Green, 532 F.3d 538, 550 (6th Cir. 2008) ("[I]t would be impossible for a district court to adequately utilize the Guideline range in making an objective decision as to the seriousness of a particular crime. Most often, the Guideline range is not determined finally until after a defendant has been convicted and a presentence investigation report has been completed."). The Tenth Circuit has considered both the statutory maximum and the likely sentence under the guidelines. *See* United States v. Valenzuela-Puentes, 479 F.3d 1220, 1226 (10th Cir. 2007).

[77] *But see Forcibly Medicating*, *supra* note 74, at 1127 ("Given the broad determination that is being made here—whether or not a serious crime has been committed—reference to a potential Guidelines range is more effective, and fairer to the defendant, than reference to the statutory maximum."). In practice, the difference between a statutory maximum sentence and a projected guidelines sentence is unlikely to mean the difference between an offense that is "serious" and one that is "not serious."

[78] *See id.* at 1126 ("Most courts have judged the importance of bringing a defendant to trial based on the maximum penalty the defendant could face if convicted.").

[79] Sell v. United States, 539 U.S. 166, 180 (2003) ("Courts, however, must consider the facts of the individual case in evaluating the Government's interest in prosecution. Special circumstances may lessen the importance of that interest.").

B. A Judicial Ruling on Offense Seriousness at the Time of Commitment

Another way that *Sell* could be amended to allow medical personnel to make decisions regarding administering involuntary medications would be for the court to decide whether the government's interest in rendering the defendant competent to stand trial is important enough to justify the administration of involuntary medications at the same time that the court decides that the defendant is incompetent to stand trial and orders the defendant committed for the purpose of rendering him competent.[80] Once the judge decides that the charges against the defendant are serious enough, and that no special circumstances diminish the government's interest in rendering the defendant competent to stand trial, the other three *Sell* factors could be left to the determination of medical personnel. Ideally, if the charges are serious enough to warrant commitment, there should be few cases in which the charges are not serious enough to justify involuntary medications. Although some courts—though never the Supreme Court—have ruled that involuntary medication is "more intrusive" than commitment,[81] commitment still is "a massive curtailment of liberty"[82] and should always require a fairly substantial government interest. But regardless of how many cases there are in which the trial court rules that the government's interest is not important enough to justify involuntary medications, having the trial court make this determination at the time that the defendant is committed would benefit both the defendant and the government by allowing medical personnel to then make decisions in a relatively timely manner about administering involuntary medications to pretrial detainees who are not dangerous.

C. A Limited Defense of the Professional judgment Standard

The recommendation that medical personnel rather than judges should make the decision whether to administer involuntary antipsychotic medications to incompetent pretrial detainees is subject to the criticism that medical personnel are inadequate protectors of a detainee's liberty interest in refusing unwanted medical treatment. Many critics of the professional judgment standard have argued that medical personnel are likely to overvalue the benefits of medications and to undervalue the harms.[83]

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[80] Under federal law, this decision is governed by 18 U.S.C. § 4241, which directs courts first to determine whether the defendant is incompetent to stand trial, and if he is incompetent, to commit him for the purpose of determining whether he can be rendered competent. At the same time that the court decides these two things, it could also decide whether the charges against the defendant are serious enough to justify involuntary medications, also taking into account any special circumstances that might offset the seriousness of the charges and result in the government's interest in bringing the defendant to trial not being important enough to justify involuntary medications. 18 U.S.C. § 4241 (2006).

[81] *See*, *e.g.*, Bee v. Greaves, 744 F.2d 1387, 1396 (10th Cir. 1984) ("[L]ess restrictive alternatives, such as segregation . . . should be ruled out before resorting to antipsychotic drugs."); Rennie v. Klein, 653 F.2d 836, 844 (3d Cir. 1981) ("[T]here is a difference of constitutional significance between simple involuntary confinement to a mental institution and commitment combined with enforced administration of antipsychotic drugs."); Rogers v. Okin, 634 F.2d 650, 656 (1st Cir. 1980) ("[R]easonable alternatives to the administration of antipsychotics must be ruled out."); In re Guardianship of Roe, 421 N.E.2d 40, 52 (Mass. 1981) ("We can identify few legitimate medical procedures which are more intrusive than the forcible injection of antipsychotic medication.").

[82] Humphrey v. Cady, 405 U.S. 504, 509 (1972).

[83] *See* Elyn R. Saks, *Competency to Refuse Psychotropic Medication: Three Alternatives to the Law's Cognitive Standard*, 47 U. MIAMI L. REV. 689, 760 (1993) ("The theory is that it is better to treat someone who is not sick than to fail to treat someone who is. As a result, physicians also tend to err on the side of recommending unnecessary or

These criticisms might be grounds for retaining judges as the decision-makers in typical involuntary treatment cases. In these cases, the question before the decision-maker is whether the person is competent to make his own medical treatment decisions. But these criticisms are misplaced when the purpose of involuntary treatment is to render a person competent to stand trial, because in these cases, it does not matter whether the person is competent to make his own medical treatment decisions.

Once the court has ordered a criminal defendant committed for the purpose of becoming competent to stand trial, the test for determining whether involuntary medication is permitted does not ask the decision-maker to consider the defendant's competency to make his own medical treatment decisions. Instead, under *Sell*, the decision-maker must determine whether the government has an important interest in bringing the defendant to trial, whether medications are substantially likely to render the defendant competent without causing side effects that will interfere with trial rights, whether there are any less intrusive means of rending the defendant competent to stand trial, and whether the medications are medically appropriate.[84]

The first factor, whether the government has a sufficiently important interest to justify involuntary medications, is one that must be determined by a judicial decision-maker; this article proposes that this judicial determination need not be made in a separate proceeding, but instead could be made either by establishing a bright-line rule of offense seriousness or by assessing the government's interest at the time the court orders the defendant committed for the purpose of being made competent to stand trial. The other three factors, though, can be determined by medical personnel without risking an unjustified compromise of a detainee's liberty interests. As a practical matter, neither courts nor medical personnel can make individualized assessments of the second factor, because how a particular person will respond to a particular antipsychotic medication cannot be predicted with any accuracy beyond statements of general tendencies.[85] The third factor supposes that there might be less intrusive means of rendering a detainee competent, but given that antipsychotic medications are the only effective treatment for active psychotic symptoms, it is not likely that any decision-maker, whether judge or medical personnel, would come to any conclusion other than that there is no less intrusive means.[86] Concerning the fourth factor, it is difficult to imagine a question more appropriately left to medical personnel than

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unhelpful treatment-of overtreating.") (footnote omitted); Trudi Kirk and Donald N. Bersoff, *How Many Procedural Safeguards Does It Take to Get a Psychiatrist to Leave the Lightbulb Unchanged? A Due Process Analysis of the MacArthur Treatment Competence Study*, 2 PSYCHOL. PUB. POL'Y & L. 45, 67 (1996) ("[M]edical model decision makers are compelled to provide treatment and therefore may not make a reasoned decision as to the value of treatment to an individual. To the medical model decision maker, treatment is always best, and the medically determined 'best' treatment is always desired over the less effective one.").

[84] Sell v. United States, 539 U.S. 166, 180-81 (2003).

[85] *See supra* note 44.

[86] *See* Brief for the Am. Psychiatric Ass'n and Am. Acad. of Psychiatry and the Law as Amici Curiae Supporting Respondent at 13–14, Sell v. United States, 539 U.S.166 (2003) (No. 02-5664) ("Antipsychotic medications are not only an accepted but often essential, irreplaceable treatment for psychotic illnesses, as most firmly established for schizophrenia, because the benefits of antipsychotic medications for patients with psychoses, compared to any other available means of treatment, are so palpably great compared with their generally manageable side effects."); John M. Kane, *Conventional Neuroleptic Treatment: Current Status, Future Role*, *in* THE NEW PHARMACOTHERAPY OF SCHIZOPHRENIA 89, 90 (Alan Breier ed., 1996) (describing antipsychotic medications as "the primary modality in the treatment of an acute episode or an acute exacerbation of a schizophrenic illness"); Thomas H. McGlashan, *Rationale and Parameters for Medication-Free Research in Psychosis*, 32 SCHIZOPHRENIA BULL. 300, 301 (2006) (noting that antipsychotic medications are "the most rapid, effective, and economical treatment for active psychosis").

the question whether medications are medically appropriate. Additionally, a mechanism for judicial review of the decisions of medical personnel is already built into the federal system: an initial commitment for the purpose of rendering a defendant competent to stand trial is for four months; after which the court will authorize continued commitment only if "his mental condition is so improved that trial may proceed, if the court finds that there is a substantial probability that within such additional period of time he will attain the capacity to permit the proceedings to go forward."[87] At the same time that the court considers the appropriateness of continued commitment, the court could also consider the appropriateness of any decisions that medical personnel have made to administer involuntary antipsychotic medications.

IV. CONCLUSION

Given *Sell*, delay is, for now at least, unavoidable if an incompetent pretrial detainee refuses to take voluntarily the antipsychotic medications that might make him competent, and the government seeks to administer involuntary medications for the purpose of rendering the detainee competent to stand trial. The delay could be avoided if the decision in *Sell* was revisited and procedures for assessing the importance of the government's interest in bringing the defendant to trial were adopted that would allow the decision whether to administer involuntary medications for the purpose of rendering the defendant competent to stand trial to be made by medical personnel. But there is no good reason to compound the problem by requiring judicial rulings when the government seeks to administer involuntary antipsychotic medications for the purpose of diminishing a detainee's dangerousness. Of course, the detainee's fair trial rights are the same regardless of the purpose for which involuntary medications are administered. And if a judicial ruling about trial rights before administering involuntary medications could protect the detainee's fair trial rights, then a judicial ruling should perhaps be required. But a judicial ruling does not protect the detainee's trial rights—because the detainee's response to antipsychotic medications cannot be predicted. As Justice Kennedy said in *Riggins*, perhaps someday we will have better antipsychotic medications.[88] Until then, we must make the best of what we have. Allowing medical personnel to decide whether to administer involuntary antipsychotic medications to incompetent pretrial detainees is a step in the right direction, because it avoids the delays that accompany judicial determinations and thereby minimizes the amount to time that detainees are left to experience the untreated symptoms of psychosis. And avoiding delay in the administration of antipsychotic medications serves both the defendant's and the government's interests.

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[87] 18 U.S.C. § 4241 (2006).

[88] Riggins v. Nevada, 504 U.S. 127, 145 (1992) (Kennedy, J., concurring) ("The state of our knowledge of antipsychotic drugs and their side effects is evolving and may one day produce effective drugs that have only minimal side effects.").