

# **Sell v. U.S.: Involuntary Medication to Restore Trial Competency—A Workable Standard?**

Joan B. Gerbasi, JD, MD, and Charles L. Scott, MD

Competency to Stand Trial (CST) evaluations are common in the U.S. criminal justice system. Of those defendants found Incompetent to Stand Trial (IST), psychotic disorders are the most common diagnoses, and active psychotic symptoms are strongly correlated with impairments in trial-related abilities. If a defendant is rendered IST because of psychosis, restoration will be unlikely without antipsychotic medication. Last term, in *Sell v. U.S.*, the U.S. Supreme Court dealt with medication refusal in the context of competency restoration. The Court held that involuntary medication, under certain circumstances, is appropriate. This article includes a review of earlier relevant legal decisions and an analysis and discussion of the *Sell* decision.

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Competency to stand trial (CST) evaluations are common in our criminal justice system.<sup>1</sup> One study estimated that there are nearly 50,000 evaluation requests each year.<sup>2</sup> Of those defendants referred for evaluation, the percentage eventually adjudicated IST has been estimated at between 10 and 30 percent.<sup>3</sup> Of those defendants found incompetent to stand trial (IST), psychotic disorders are the most common diagnosis. Research indicates that between 45 and 65 percent of defendants evaluated for competency who have schizophrenia or other psychotic illnesses are found IST.<sup>4–7</sup> In a study published by the MacArthur Foundation Research Network on Mental Health and the Law,<sup>8</sup> 65 percent of defendants hospitalized as IST had a diagnosis of schizophrenia. Although the presence of psychosis does not necessarily lead to a finding of IST, active psychotic symptoms (such as hallucinations and conceptual disorganization) are strongly correlated with impairments in trial-related abilities.<sup>8–11</sup>

If a defendant is rendered IST because of psychosis, restoration is unlikely without antipsychotic medication. But what if a defendant refuses medica-

tion? What can the government do? Under what circumstances can the government force a defendant to take medication? The question of forced medication was addressed in the recent Supreme Court case of *Sell v. U.S.*<sup>12</sup> The following is a review of earlier relevant legal decisions and an analysis and discussion of the *Sell* decision.

## **Background**

The Supreme Court has twice dealt with involuntary medication in the criminal justice system. In 1990, the Court decided *Washington v. Harper*,<sup>13</sup> a case involving involuntary antipsychotic medication in prison. Walter Harper, the plaintiff, had a long history of mental illness. After being found guilty of robbery in 1976, he was incarcerated in the Washington state prison system for most of the next 13 years. During this time, he was treated with antipsychotic medications, which he intermittently refused. The Washington state prison procedure for treatment over an inmate's objection included several substantive and procedural components, including the provision of an administrative hearing. In compliance with this procedure, Harper's physicians obtained orders for involuntary medication.

In 1985, Harper filed suit in state court under 42 U.S.C. § 1983, challenging the prison procedure on several grounds, including that it violated the Due Process Clauses of both the federal and state consti-

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Dr. Gerbasi is Assistant Clinical Professor of Psychiatry and Director of the Forensic Psychiatry Residency and Dr. Scott is Assistant Professor of Clinical Psychiatry and Chief of the Forensic Psychiatry Division at the University of California, Davis. Address correspondence to: Joan B. Gerbasi, JD, MD, Department of Psychiatry, University of California, Davis Medical Center, 2230 Stockton Boulevard, Sacramento, CA 95817. E-mail: joan.gerbasi@ucdmc.ucdavis.edu

tutions. After the Washington State Supreme Court found for Harper, the state appealed to the U.S. Supreme Court. In ruling that the Washington state policy at issue was constitutional, the Court explicitly acknowledged that inmates “possess. . . a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment (Ref. 13, at 221–2, citations omitted).

In the case of prisoners, the interest in being free from unwanted medication must be balanced against the state’s legitimate interest in prison safety and security. The Court held that “the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will if the inmate is dangerous to himself or others and the treatment is in the inmate’s medical interest” (Ref. 13, at 227). The Court further held that a panel of medical professionals could make the medication decision. The Due Process Clause of the Fourteenth Amendment did not require a judicial decision-maker.

In 1992, the Supreme Court again dealt with involuntary medication, this time in the pretrial context.<sup>14</sup> David Riggins was charged with murder and robbery. After his arrest, he was voluntarily treated with thioridazine and an anticonvulsant. He subsequently pled not guilty by reason of insanity. In preparation for his trial, Riggins’ counsel moved the trial court for an order suspending administration of his medication until the end of the trial. Counsel were concerned that the drugs would affect Riggins’ demeanor and mental state during trial and, in addition, would deprive him of his right to show the jurors his “true mental state” as part of his insanity defense. After a hearing, the district court denied his motion. A jury found Riggins guilty and sentenced him to death.

Riggins challenged his convictions arguing, among other things, that the involuntary administration of antipsychotic medication denied him his ability to assist in his defense and prejudicially affected his attitude, appearance, and demeanor at trial, in violation of his Sixth and Fourteenth Amendment rights. The Nevada Supreme Court denied Riggins relief, but the U.S. Supreme Court granted *certiorari* and reversed the lower court.

In holding that Riggins’ constitutional rights had been violated, the Court cited its decision in *Washington v. Harper* and reasoned that if convicted pris-

oners cannot be forced to take antipsychotic medications absent a finding of overriding justification and determination of medical appropriateness, pretrial detainees must have at least as much protection (Ref. 14, at 135). It concluded that once Riggins moved to discontinue his medication, further treatment should have been predicated on the state’s demonstration of the need for and medical appropriateness of the drug. In *dicta*, however, the Court implied that involuntary medication would perhaps be justified if it was necessary to maintain Riggins’ trial competence. The Court stated: “[T]he State might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins’ guilt or innocence by using less intrusive means” (Ref. 14, at 135, citations omitted).

### **The Circuit Court Cases**

Since *Riggins*, a number of federal circuit courts have addressed directly whether the state can involuntarily medicate a defendant solely to restore trial competency. First, in *U.S. v. Brandon*,<sup>15</sup> the Sixth Circuit ruled that a judicial hearing is required before involuntary medication can be administered to restore trial competency. An administrative hearing would not pass constitutional muster. The *Brandon* court observed that the decision to administer medication is not really about whether the medication is in the defendant’s best medical interest. Rather the decision concerns whether the medication can be forced on the defendant to restore him to CST. Because the medication decision would, of necessity, involve an analysis of the effects that medication would have on the defendant’s Sixth Amendment rights, the court believed that a judicial hearing was required. It observed that an administrative hearing, using medical professionals as decision-makers, would be inadequate because medical professionals would not be equipped to decide the legal issues about trial-related rights (Ref. 15, at 955). Physicians’ testimony, however, remains very important because the court must be informed of recommendations regarding indications for and side effects of the medications.

The second relevant case, *U.S. v. Weston*,<sup>16</sup> was decided by the D.C. Circuit Court of Appeals in July 2001. Russell Weston was charged with the murders of two U.S. Capitol police officers in July 1998. Psychiatric evaluations of Weston revealed that he had a

complicated and elaborate delusional scheme involving government conspiracies, cannibalism, and a satellite system that controlled the country. Weston's competency to stand trial was questioned, and he was evaluated and found to be IST. He was sent to the Federal Correctional Institute in Butner, North Carolina, for restoration, where he refused antipsychotic medication.

After multiple hearings and court decisions, the D.C. Circuit Court of Appeals ruled that the government could administer antipsychotic drugs to Weston against his will to render him CST. The court recognized that Weston had a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs, but held that "the Government's interest in administering antipsychotic drugs to make Weston competent for trial overrides his liberty interest, and. . .restoring his competence in such [a] manner does not necessarily violate his right to a fair trial" (Ref. 16, at 876). It further held that, before the government can administer involuntary medication to restore CST, it must prove (1) that the medication is medically appropriate; (2) that restoring the defendant's CST is necessary to accomplish an essential state policy; and (3) that medication is necessary to restore CST and competency could not be restored by a less intrusive alternative.

With respect to the "essential state policy," the state argued the policy is the state's interest in adjudicating criminality. The court cited *Riggins* and stated that the "Constitutional power to bring an accused to trial is fundamental to a scheme of 'ordered liberty' and prerequisite to social justice and peace" (Ref. 16, at 881, citing *Riggins*, 504 U.S. at 135–36, quoting *Illinois v. Allen*, 397 U.S. 337, 347 (1970) (Justice Brennan, concurring)). However, the circuit court read *Riggins* as implying that the interest in adjudicating criminality is not necessarily an essential state policy under all circumstances. In this case, the court thought that it need not decide under what circumstances the state's interest in adjudicating criminality is not "essential" because: "The government's interest in finding, convicting, and punishing criminals reaches its zenith when the crime is the murder of federal police officers in a place crowded with bystanders where a branch of government conducts its business" (Ref. 16, at 881).

In 2002, two other circuits also addressed involuntary medication to restore CST. In the Second Circuit case of *U.S. v. Gomes*,<sup>17</sup> Mr. Gomes was

charged with one count of possession of a firearm by a convicted felon. Because he had prior convictions, he qualified for sentence enhancement and faced a mandatory minimum sentence of 15 years' imprisonment. Gomes was found IST and then refused medication. The district court ordered Gomes to be involuntarily medicated, and he appealed.

On appeal, the circuit court vacated the judgment of the district court and remanded for a consideration in light of the standard set forth in their opinion. The circuit court endorsed the standard articulated in *Weston* and additionally noted that the burden of proof should be on the government, by clear and convincing evidence. Significantly, the court expanded on *Weston*'s discussion of the government's interest in adjudicating criminality. It stated:

While the governmental interest will generally be essential, it is still case specific. The factors that bear on this interest include whether the crime is one that is broadly harmful, such as drug trafficking. . .or a scheme of health care fraud. . .whether it is classified as a felony and carries a substantial penalty, . . .and whether the defendant poses a danger to society, based on the charged conduct, his past conduct, or both [Ref. 17, at 85, citations omitted].

The court stated that some prosecutions "are so minor that, in the absence of some unusual compelling reason, they ordinarily will not outweigh a defendant's interest in avoiding involuntary medication" (Ref. 17, at 86). It gave examples of the first-time theft of a single letter or unlawful possession of a small amount of drugs for personal use.

Finally, the Eighth Circuit heard the *Sell* case.<sup>18</sup> Dr. Sell, a dentist, was charged with making false representation in connection with payments for health care services in violation of federal law. The government alleged that Sell and his wife submitted false claims to Medicaid and private insurance companies for dental services that had not been provided. They were charged with 56 counts of mail fraud, 6 counts of Medicaid fraud, and 1 count of money laundering. Subsequently, Sell was also charged with attempting to murder the FBI agent who had arrested him and a former employee who planned to testify against him in the fraud case.

In 1999, Sell was found IST and hospitalized for restoration services at the United States Medical Center for Federal Prisoners in Springfield, Missouri. He was diagnosed with delusional disorder and then refused antipsychotic medication. A federal magistrate approved the involuntary administration

of medication, and the decision was upheld by both a medical center administrative review and the district court. In March 2002, a divided panel of the court of appeals affirmed the district court's judgment. The circuit court focused solely on the serious fraud charges, not on the charge of attempted murder, and concluded that Sell could be medicated involuntarily.

The court agreed with the *Weston* standard, but chose to restate it in more detail: To involuntarily medicate a defendant to restore competency to stand trial, (1) the government must present an essential state interest that outweighs the individual's interest in remaining free from medication; (2) the government must prove that there is no less intrusive way of fulfilling its essential interest; and (3) the government must prove by clear and convincing evidence that the medication is medically appropriate. Medication is medically appropriate if (1) it is likely to render the patient competent; (2) the likelihood and gravity of side effects do not overwhelm its benefits; and (3) it is in the best medical interests of the patient (Ref. 18, at 567).

The court held that in this case the government's interest in restoring Sell's competency so that the 62 charges of fraud and the single charge of money laundering could be adjudicated was serious enough to override his significant liberty in refusing antipsychotic medication. The dissent argued that the charges against Sell were not sufficiently serious to inject him forcibly with antipsychotic drugs "on the chance" it would make him competent to stand trial (Ref. 18, at 572). Some of their concern in Sell's specific case was the efficacy of antipsychotic medication for treating delusional disorder.

### **The Supreme Court Decision**

Sell appealed the circuit court decision and the U.S. Supreme Court granted *certiorari*. It framed the issue as: Does the constitution permit the government to administer antipsychotic drugs involuntarily to a mentally ill criminal defendant to render the defendant competent to stand trial for serious, but nonviolent offenses? (Ref. 12, at 2178) In a six-to-three decision, the Supreme Court held that medication to restore trial competency for serious offenses could be administered involuntarily under certain circumstances. Writing for the majority, Justice Breyer stated, however, that although permissible, involuntary medication for restoration to trial com-

petence should occur only "rarely" because a court must first find that all of the following conditions are satisfied.

First, the court must find that an important government interest is at stake. As held by the *Weston*, *Gomes*, and *Sell* circuit court decisions, the government's interest is in adjudicating criminality. Here, the Supreme Court reiterated this view, and held that the government's interest in adjudicating "serious" crime, whether against person or property is important. However, it also held that other circumstances may lessen the government's interest in pursuing prosecution and that each case must be considered individually. Specifically, it noted that if a defendant's refusal to take medication voluntarily would result in a lengthy confinement in an institution, the government's interest in prosecution would be reduced because the "risks that ordinarily attach to freeing without punishment one who has committed a serious crime" would be diminished (Ref. 12, at 2185). In addition, the government has an interest in pursuing a timely prosecution that is not served if restoration is achieved only after "years of commitment during which memories may fade and evidence may be lost" (Ref. 12, at 2185). Finally, the Court noted the government's concomitant interest in assuring the defendant a fair trial.

Second, the court must find that the medication significantly furthers the state's interests. Medication must be substantially likely to render the defendant competent to stand trial and substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel and thereby render the trial unfair (Ref. 12, at 2185).

Third, the court must find that the medication is necessary to further the state's interests, meaning that medication must be the most appropriate method of restoration. Specifically, the opinion states that "the court must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results." To support this statement, the Court references an *amicus* brief from the American Psychological Association that indicates that nondrug therapies can be effective in restoring competence of psychotic defendants (Ref. 12, at 2185). In addition, the medication must be administered by the least intrusive route possible (e.g., court order for oral medication enforced by threat of contempt as opposed to a court order for medication by injection).

Finally, the court must find that the medication is medically appropriate. The opinion defines “medically appropriate” as “in the patient’s best medical interest in light of his medical condition” (Ref. 12, at 2185). The opinion also emphasizes that specific categories of medications at issue should be considered in light of their respective efficacy and side-effect profiles.

The majority stressed, however, that employing these four criteria should rarely be necessary, because the government must look to alternative grounds for involuntary medication before administering involuntary medication to restore trial competence. These grounds include involuntary medication administered to control dangerousness or because the individual lacks the capacity to give informed consent (or refusal) for medication. The Court viewed the inquiry into whether medication is permissible to render an individual nondangerous as more “objective and manageable” than the inquiry into medication to restore CST (Ref. 12, at 2185). The opinion states:

The medical experts may find it easier to provide an informed opinion about whether, given the risks 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 [Ref. 12, at 2185].

The Court also observed that every state has civil procedures to deal with the involuntary administration of medication to patients who lack the mental competence to make such decisions.

The Court stated a clear preference for dealing with involuntary medication on civil grounds, rather than reaching the trial competence grounds. It observed that authorizing medication on these grounds would often be possible and would eliminate the need to consider authorization on trial competence grounds. In addition, even if a court decides that medication is not permissible on these alternative grounds, the inquiries would help inform and crystallize the competence-related arguments. It stated:

[These findings] will facilitate direct medical and legal focus upon such questions as: Why is it medically appropriate forcibly to administer antipsychotic drugs to an individual who (1) is *not* dangerous *and* (2) is competent to make up his own mind about treatment? Can bringing such an individual to trial *alone* justify in whole (or at least in significant part) administration of a drug that may have adverse side effects, including side effects that may to some extent impair a defense at trial? We consequently believe that a court, asked to approve forced administration of

drugs for purposes of rendering a defendant competent to stand trial, should ordinarily determine whether the Government seeks, or has first sought, permission for forced administration of drugs on these other *Harper*-type grounds; and if not, why not. [Ref. 12, at 2186, emphasis in original].

With respect to Dr. Sell, the Court found that the Eighth Circuit erred in approving medication solely to render him competent to stand trial. It stated that the lower court’s inquiries focused mainly on dangerousness, rather than on the appropriateness of involuntary medications to restore competency. Moreover, the circuit court did not consider medication side effects that could have affected the trial’s fairness (sedation, decreased expression of emotion) or that Dr. Sell had been confined for a several years and might be confined for an even longer time because of his refusal to be medicated. The case was remanded for further consideration in light of the Court’s opinion.

Justice Scalia wrote a dissenting opinion, joined by Justices O’Connor and Thomas. The dissent argued that the circuit court did not have jurisdiction to hear the case and should have dismissed it. In a criminal case, appellate review is normally prohibited until conviction and imposition of sentence. If the defense objects to a trial court order, the order is respected and the trial proceeds. If the defendant is convicted, grounds for appeal would include that the trial court order was in error. There is, however, an exception known as the “collateral order” doctrine. Under this doctrine, appeal of a trial court order is permissible if the trial court order (1) “conclusively determine[s] the disputed question,” (2) “resolve[s] an important issue completely separate from the merits of the action,” and (3) is “effectively unreviewable on appeal from a final judgment” (Ref. 19, p 468).

The dissent’s view was that the district court’s order permitting Sell to be medicated did not satisfy the requirements of the “collateral order” exception to the final judgment rule because an appeal after final judgment was available. Sell would still receive relief, through a postdeprivation vacation of his conviction, as happened in *Riggins*, rather than a predeprivation injunction. The majority had ruled that the “collateral order” exception was met and stressed that relying on postdeprivation remedies would mean that Sell would have to undergo forced medication—the very harm he sought to avoid—and that that harm could not be undone, even if he were acquitted.

The dissent emphasized that the Court's ruling will "allow criminal defendants in petitioner's position to engage in opportunistic behavior...[and] hold up the trial for months by claiming that review after final judgment 'would come too late' to prevent violation" of his rights (Ref. 12, at 2190). Justice Scalia also pointed out that these appeals would, if the majority's ruling is applied faithfully, include appeals from any trial court order that allegedly causes an infringement on constitutional rights, not only those orders having to do with medication.

## Discussion

While the Supreme Court has answered some questions with respect to involuntary medication to restore CST, it has created others. First, the Court agreed with the Sixth Circuit's decision in *Brandon*, making it clear that a judicial hearing is necessary before a defendant can be forcibly medicated to restore CST. Although not explicitly addressed, the Court refers to "court" findings throughout its discussion of the *Sell* standard. In contrast, the *Harper* Court held that a judicial decision-maker was not required to medicate a dangerous prisoner involuntarily and that a panel of mental health professionals would suffice. This heightened requirement is probably related to the Sixth Amendment rights of pre-trial detainees that are at stake in the CST context, but not in the *Harper* context, which involved convicted prisoners.

The Supreme Court emphasized that alternative grounds for involuntary medication should be pursued before even addressing forced medication to restore competency. These grounds include capacity to consent to medication and dangerousness. With respect to the capacity to consent to medication, this inquiry is well defined. It is an analysis of the individual's ability to understand and appreciate the indications for; the risks, benefits, and side effects of; and the alternatives to the medication. As the majority opinion points out, all states have procedures to deal with this issue.

Although the informed consent inquiry is well defined and states have clear procedures and rules in place, the dangerousness inquiry is more problematic. First, predicting violence, even in the short term, remains an inexact science. Even if the prediction could be made with an acceptable degree of accuracy, it is unclear what risk would constitute "dan-

ger" sufficient to justify involuntary medication before trial.

In the civil arena, some states require that danger be imminent before a patient can be involuntarily medicated. In all other cases, authorization for involuntary medication must be predicated on the patient's incompetence to consent to the medication; dangerousness alone cannot be grounds for forced medication.<sup>20</sup> In the prison context, however, under *Harper*, involuntary medication can be administered as long as the relevant decision-maker finds that the medication is in the prisoner's best medical interest and is necessary to prevent danger, regardless of the inmate's competence to give informed consent. Note that because the medication order is one for repeated rather than one-time medication, the prerequisite level of danger, by definition, is less than imminent danger.

In the competency-restoration pretrial context, the definition of "danger" is unclear. Restoration is usually conducted in a forensic psychiatric hospital. Does the state have a security interest in the forensic hospital setting that approximates its security interest in prison? If it does, a looser definition of danger may be appropriate. Or is a forensic hospital more like a civil hospital? In that case, depending on the jurisdiction, more imminent danger may be necessary to justify involuntary medication.

While the *Sell* Court did not directly address this matter, it did, in *dicta*, provide some guidance. In reviewing the lower court's analysis, the Court noted that the court of appeals ruled that *Sell* was not dangerous and could not be involuntarily medicated on those grounds. Apparently, *Sell* had not been violent while at the hospital, but behaved inappropriately with one of the nurses. He approached her and told her that he was in love with her and then criticized her for not returning his affection. When told that his behavior was inappropriate, *Sell* apparently responded, "I can't help it" (Ref. 12, at 2180, internal citations omitted). His doctors testified that, given *Sell*'s prior behavior, diagnosis, and current beliefs, his behavior toward the nurse was not harmless and made him a safety risk, even within an institution. The district court found, however, that since *Sell* was being managed in an open ward at the time of the ruling and had not been violent in that context, he was not dangerous. This finding was affirmed by the court of appeals. The Supreme Court, however, stated, "We shall assume the Court of Appeals' con-

clusion about Sell's dangerousness was correct. But we make that assumption only because the Government did not contest, and the parties have not argued, that particular matter. If anything, the record before us . . . suggests the contrary" (Ref. 12, at 2186). This statement implies that the relevant standard would not even require overt acts of violence or threats of violence in the institution. In this case, at most, Sell was behaving in a overly familiar manner, which was of more concern than it might otherwise be, given his history and diagnosis.

Turning to the Court's explicit criteria for medication solely to render a defendant CST, there are again some concerns. First, although the Court holds that the state's interest in adjudicating criminality in a specific case must be "important," this phrasing offers little guidance regarding the limits of this interest. The *Weston*, *Gomes*, and *Sell* circuit court decisions all struggled with the limits of the government's power. The question of when a crime is not sufficiently serious to warrant forced medication to bring the defendant to trial was discussed directly in the *Sell* circuit court decision and the dissent, in fact, believed that Dr. Sell's fraud charges were not sufficiently serious to warrant forced medication. In granting *certiorari*, it seemed that the Supreme Court would address this question. The lower courts seemed in agreement on nearly everything else. However, beyond stating that the "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" (Ref. 12, at 2184), the Supreme Court is silent, thus leaving unanswered a question that troubled the lower courts.

In addition, the standard states that the government's interest in bringing a defendant to trial may be lessened if a defendant would be subject to a lengthy confinement if he is not medicated. Part of the Court's concern here is probably the fact that Sell had been hospitalized for several years while his case was being litigated. In most cases, however, the medication hearing takes place early in the hospitalization, and a realistic appraisal of the likelihood of a "lengthy" hospitalization is difficult, if not impossible.

Under the Supreme Court's decision in *Jackson v. Indiana*,<sup>21</sup> a defendant found IST can be held involuntarily in a hospital only for a reasonable time to determine whether restoration is likely in the foreseeable future. If it becomes clear that restoration is unlikely, the defendant must be either released or committed under the relevant civil commitment criteria. In the case of a defendant who refuses necessary medication, his competency by definition becomes unrestorable without the medication. Under *Jackson*, the commitment must terminate. State standards for the civil commitment of defendants who are unrestrictably IST vary, but are generally predicated on some finding of dangerousness beyond the violence of the alleged crime. Proving this can be difficult, especially if the defendant has not been violent in the hospital. Further, this type of commitment can require proof beyond a reasonable doubt and give the defendant the right to a jury trial.<sup>22</sup> It seems unlikely that judges would be able to predict the outcome of these trials with any acceptable degree of accuracy. Even if it were possible, it is entirely unclear how much weight this information should be given—that is, when should it effectively neutralize the state's interest in bringing a defendant to trial?

## Conclusion

The issue of involuntary medication to restore competency to stand trial is a complicated one. When the Supreme Court granted *certiorari* on the *Sell* case, it seemed that the matter would finally be settled. Unfortunately, that has not turned out to be the case. The Court made it clear that, under certain circumstances, the government can forcibly medicate a defendant solely for purposes of competency restoration. However, as described earlier, those "circumstances" are not clear. We must wait for the decision to be interpreted and implemented and then for new legal challenges to be mounted before we can have more definitive answers.

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