Sell v. U.S.: Involuntary Treatment Case or Catalyst for Change?

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The 2003 U.S. Supreme Court decision in *Sell v. U.S.*[1] dealt with the involuntary administration of antipsychotic medication to an incompetent pretrial defendant. The Court's holding set forth what has quickly become known as the "*Sell* criteria." These four criteria can be paraphrased as:

(1) Did the defendant commit a serious crime?

(2) Is there a substantial likelihood that involuntary medication will restore the defendant's competence and do so without causing side effects that will significantly interfere with the defendant's ability to assist counsel?

(3) Is involuntary medication the least intrusive treatment for restoration of competence?

(4) Is the proposed treatment medically appropriate?

None of these criteria breaks new ground as far as psychiatry is concerned. The first criterion of what constitutes a "serious" crime is solely a legal question. The third and fourth criteria were highlighted over a decade ago in *Riggins v. Nevada*.[2] Only the second *Sell* criterion appears novel from the mental health perspective. However, the U.S. Supreme Court previously addressed the nonrestorability of competence to stand trial in *Jackson v. Indiana*[3] and involuntary use of antipsychotic medications in *Washington v. Harper*.[4] What is "new" for mental health purposes is how the U.S. Supreme Court combined these concepts. Clinical input may be particularly important in guiding the judicial decision maker in what constitutes a substantial likelihood of restoration. The second part of the second *Sell* criterion has less practical importance, since the newer generation of antipsychotic medications significantly reduce or in some instances eliminate the disturbing extrapyramidal side effects that have been the point of focus as a vehicle of potential unfairness to the defendant. Although the newer antipsychotics have been associated with potential adverse metabolic side effects in some patients, these side effects are not likely to arise during the course of the criminal case and, if they do, would not be expected to impact the defendant's competency to proceed.

Commentary and discussion immediately followed the Court's *Sell* decision,[5–8] including presentations at the October 2003 Annual Meeting of the American Academy of Psychiatry and the Law.[6,7] Shortly thereafter, even the *New England Journal of Medicine*'s legal commentator jumped into the debate.[9] As expected, additional exploration of the *Sell* case has followed from both the mental health and legal fields, especially from the latter. The post-*Sell* analysis has focused primarily, and rightfully so, on the Court's holding or *Sell* criteria and its impact on the involuntary medication question. For example, California overhauled the procedures involving incompetent defendants in 2004 (see Senate Bill 1794 which amended sections 1369, 1370, and 1370.01 of the California Penal Code) and the Second and Fourth Circuit Courts of Appeals have weighed in on it in *U.S. v. Gomes*[10] and *U.S. v. Evans*.[11]

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Although *Sell* focused on a narrow part of the question, it has already had considerable influence on both the mental health and legal systems. At a minimum, it has added another layer of judicial review to the process of restoration of competence to stand trial. No doubt additional time and money will be spent debating and arguing over the *Sell* criteria at the trial and appellate court levels beyond the recent post-*Sell* circuit court of appeals cases.[10,11] Outside of these direct expenditures of time and financial resources lies potentially costly indirect fallout from the *Sell* decision. Before proceeding with the analysis, a brief exploration of the recent history of public sector psychiatry is in order.

Criminalization of the Mentally Ill

Going back approximately a half century to the time before the use of antipsychotic medications, state psychiatric hospitals cared for many of the seriously mentally disordered individuals. The advent of antipsychotic medications gave rise to the hope of substantially reducing the inpatient psychiatric population. Politicians seized the moment, and the reduction in the number of inpatient psychiatric beds began. This could arguably be considered the progenitor of utilization review and managed care. The promise of the community care system promulgated by the Community Mental Health Centers Act of the early 1960s as a viable substitute for inpatient psychiatric care fell short. Instead, fiscal support for both inpatient and outpatient psychiatric services have experienced continued erosion.

The confluence of the aforementioned events resulted in the phenomenon that has come to be known as the "criminalization of the mentally ill," as evidenced by the county jail's subsuming the role as the largest local public mental health facility and forensic patients' forming the dominant group in state mental health facilities. With the front door to treatment services often closed or barricaded for a variety of reasons, a "back door" entry to mental health treatment has often been used through commitment to state psychiatric facilities for restoration of competency to stand trial, also known as "pseudocivil commitment"[12] or via the less frequently used insanity defense for mentally disordered misdemeanants.[13]

The *Sell* Case as a Catalyst for Change

Taking another look at *Sell v. U.S.* beyond the narrow issue of involuntary treatment and focusing on the potential consequences of the decision creates an intriguing possibility. In *dicta* written in the majority opinion of *Sell v. U.S.* we find reference to the use of civil courts in a criminal matter and the civil commitment dangerousness threshold for the administration of involuntary treatment. This seems odd, given that the two cases the *Sell* court relied on to formulate the decision come from the criminal system, namely *Riggins v. Nevada*[2] and *Washington v. Harper*.[4] Nonetheless, the *Sell* case suggests that certain mentally ill defendants might be better served in the civil system. In other words, although the Court probably did not intend a far-reaching effect on the civil-criminal dichotomy for the mentally disordered, the *Sell* decision may be the vehicle to catalyze a movement toward "decriminalization" of the mentally ill.

The hypothesis that the potential effect of *Sell* reaches beyond the matter of involuntary medication also finds support in considering the first two *Sell* criteria, namely that the seriousness of the charged crime and the likelihood of restoration be considered. In regard to the first *Sell* criterion, although the seriousness of the crime will no doubt be a subject of litigation for some time to come, it does suggest an entire class of defendants to whom competency restoration may not apply. This could very well shift defendants in the criminal justice system back into patients in the civil mental health system. Of course, the civil system is probably ill equipped to deal with the influx of additional patients whom the civil system actively or passively transfers to the criminal system.[12–14] Moreover, the current laws would then not adequately address the very real problem of a group of individuals who would utilize loopholes in existing laws to evade both treatment and prosecution as they persistently reoffend.

The second *Sell* criterion of restorability needs clinical investigation. Although managed care and utilization review have reduced inpatient psychiatric treatment to several days, commitment for competency restoration has generally maintained lengthier time frames, commonly an initial 90-day period with the possibility of additional commitment time. Even with this additional treatment time, which often involves a multimodal approach consisting of psychopharmacological, psychological, psychosocial, and educational interventions, many individuals fail to have their competence restored. Unfortunately, on expiration of their time in the criminal system, trans-

fer back to the civil system when permitted by law, often leads to their premature release into the community, since civil mental health rules then apply, after which reentry into the criminal system often recurs.

This analysis suggests that *Sell* reiterates the challenge not only to the mental health system, but also to society as a whole, to reconsider the artificial boundary between the criminal and civil systems with regard to the mentally disordered. *Sell* suggests that the public mental health sector and mental health law need deconstructing and a major overhaul, so that a seamless entity forms and we do not have three classes of public mental health sector patients: those in the civil system, those in the criminal system, and those being recycled between the two in an endless loop. Reconfiguring the present system to reduce the disenfranchisement of at least some mentally disordered individuals in the criminal justice system would involve both revision of state statutes and restructuring of public mental health services—that is, a significant overhaul by the legal and mental health systems. Even if *Sell* had no explicit intention of fostering a "decriminalization" force, the decision has altered the traditional concept of the "revolving door" phenomenon in public psychiatry and the "back door" to treatment via "criminalization of the mentally ill," and has added the "trap door" to the labyrinthine maze that the mentally disordered have to navigate.

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