bined approach involving both policy reform and smoking cessation treatment is likely to yield the greatest short- and long-term benefits, to both prisoners and prisons. Clear policies can better address prisoner ETS exposure and potential liability for prisons. Treatment programs afford prisoners the opportunity and skills to quit smoking permanently, while benefiting prisons by reducing medical costs and furthering policy-related goals. Expansion of prison smoking-cessation programs should be considered as an important next step.

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Forced Medication to Restore Competency

Tobias Wasser, MD
Fellow in Forensic Psychiatry

Kevin Trueblood, MD
Assistant Clinical Professor of Psychiatry

Law and Psychiatry Division
Department of Psychiatry
Yale University School of Medicine
New Haven, CT

Involuntary Medication Order to Restore Defendant's Competence to Stand Trial Upheld Using *Sell* Criteria

In *United States v. Dillon*, 738 F.3d 284 (D.C. Cir. 2013), the United States Court of Appeals for the District of Columbia Circuit, relying heavily on criteria set forth in *Sell v. United States*, 539 U.S. 166 (2003), affirmed the district court's decision to medicate an inmate involuntarily with psychotropic medications for the purpose of competency restoration.

Facts of the Case

On December 10, 2011, Simon Dillon, who had a history of psychiatric hospitalizations, is alleged to have sent an e-mail to a United States Secret Service Agent from a location three blocks from the White House. The e-mail stated that "no harm would come to the President if he met with Mr. Dillon and agreed to meet the demands of God" (*Dillon*, p 288). The e-mail went on to state that if, however, these demands went unmet, the president would "get the worse [*sic*] Christmas present ever," "will suffer for 30 days," and "will wish for death, but death will not come to him" (*Dillon*, p 288). The next day, Mr. Dillon was arrested and detained by the U.S. Secret Service. On January 5, 2012, he was civilly committed to outpatient treatment by the D.C. Department of Mental Health. On January 13, 2012, a grand jury indicted Mr. Dillon for threatening to inflict bodily harm on the president.

During the course of his incarceration and pretrial hearings, Mr. Dillon's competency to stand trial was evaluated on three separate occasions. In March 2012, Drs. William Ryan and Elissa Miller diagnosed his condition as paranoid schizophrenia and concluded that he was competent to stand trial, despite reporting that he was "unable to rationally consider an Insanity Defense to which he may be entitled" (*Dillon*, p 288). Following this evaluation, both parties moved for further psychiatric evaluation. In August 2012, Dr. Heather Ross evaluated Mr. Dillon, diagnosed delusional disorder, grandiose type, and concluded that he was incompetent to stand trial due to his inability to assist properly in his defense. He was subsequently committed to the custody of the Attorney General for a determination regarding his restorability. In February 2013, Drs. Jill Grant and Jill Volin authored a competency restoration report in which they diagnosed schizoaffective disorder, bipolar type in Mr. Dillon and concluded that he remained incompetent to stand trial. They opined that there was a substantial probability that he could be restored to competency with antipsychotic medication, citing multiple competency restoration studies and his history of favorable responses to psychotropic medications.

Following this evaluation, Drs. Grant and Volin requested a judicial order under *Sell* authorizing a course of involuntary medication to restore Mr. Dillon's competency. In particular, the doctors sought authorization for involuntary medication under *Sell* because they did not believe Mr. Dillon met criteria under *Washington v. Harper*, 494 U.S. 210 (1990) (i.e., dangerousness to self or others). In April 2013, the district court conducted a *Sell* hearing. Mr. Dillon disputed the doctors' findings, testifying that his past psychosis was due to prior use of peyote and that he had suffered side effects of severe depression and extremity numbness after receiving the antipsychotic Risperdal. At the conclusion of the hearing, the district court authorized the use of involuntary medications to restore Mr. Dillon's competency.

On October 24, 2013, Mr. Dillon appealed this decision to the United States Court of Appeals for the District of Columbia Circuit. His first argument was that the district court erred in failing to consider whether the possibility of his being civilly confined should have been considered a special circumstance, as described in *Sell*, which undermined the government's interest in his prosecution. Second, he argued that the district court erred in neglecting to weigh his lack of dangerousness appropriately, which should also diminish the government's interest in prosecuting him under *Sell.* (The first *Sell* factor states that to medicate someone involuntarily to restore his competency, important governmental interests must be at stake, but that certain "special circumstances" may lessen the importance of that interest.) Finally, Mr. Dillon contended that the district court's findings were erroneous in regard to his psychiatric diagnosis and the likelihood that his competency would be restored with medication.

Ruling and Reasoning

The court of appeals affirmed the district court's decision based largely on previous case law from *Sell* and *Harper*, as well as *Riggins v. Nevada*, 504 U.S. 127 (1992). The court of appeals first addressed Mr. Dillon's contentions regarding the district court's failure to consider the two special circumstances under the first *Sell* factor: the likelihood of his facing a lengthy civil confinement and his own purported nondangerousness. They found no merit in Mr. Dillon's claim that the district court erred in failing to consider the prospect that he might face civil commitment, as he had not proffered that he was likely to be civilly committed, thus forfeiting this potential argument. Further, the court found that the record offered insufficient evidence to support the proposition that he was likely to be civilly confined, citing his outpatient civil commitment (i.e., he was not dangerous enough to require inpatient commitment), and indicated that outpatient commitment was not equivalent to confinement as a special circumstance. Further, they found that Mr. Dillon's claim was thwarted by his repeated assertions that he is not dangerous, thus decreasing the likelihood of inpatient civil commitment.

The court of appeals next ruled on Mr. Dillon's assertion that his nondangerousness should render the prosecution of his case less important. Citing previous case law (*United States v. Mackey*, 717 F.3d 569 (8th Cir. 2013) and *United States v. Ruiz-Gaxiola*, 623 F.3d 684 (9th Cir. 2010)) that a defendant's dangerousness amplified the government's prosecutorial interest under *Sell*, Mr. Dillon argued that his nondangerousness should subsequently diminish the government's interest, stating, "[I]f dangerousness bolsters the government's interest under *Sell*, the lack thereof must have the opposite effect" (*Dillon*, p 295). The appeals court found that courts are constrained by the nature of charges for which the defendant is indicted. Thus, in this case, given that Mr. Dillon was charged with a serious and dangerous crime, it would be hard to say that the defendant was totally not dangerous without first adjudicating the crime, which could not be completed unless the defendant was competent.

Finally, the court of appeals addressed Mr. Dillon's claims regarding his psychiatric illness and likelihood of restoration, concluding that the factual findings were not clearly erroneous. He had asserted that medication was not substantially likely to restore his competency and would cause significant side effects (e.g., depressed mood and extremity numbness) that would interfere with his defense. He argued that the correct diagnosis was not schizoaffective disorder, but in fact, delusional disorder, a diagnosis for which there is insufficient evidence that medication leads to restoration of competency. The appeals court did not find merit in this argument, agreeing with the district court in crediting the schizoaffective diagnosis made by Drs. Grant and Volin, given that these doctors had spent more time observing Mr. Dillon, had more information available to them, and had cited the evidence in his records supporting a mood disorder diagnosis. Further, the appeals court contended that even if the correct diagnosis were delusional disorder, there was evidence from his own history and in the literature of a likelihood of restoration with the use of antipsychotic medication (Cochrane RE, Herbel BL, Reardon ML, *et al*: The *Sell* effect. . . . *Law & Hum Behav* 37:107–16, 2013).

Discussion

Dillon raises several important questions for forensic psychiatrists regarding a defendant's dangerousness as it pertains to involuntary medication. In the present case, Mr. Dillon argued that

his purported nondangerousness made his prosecution a lesser governmental interest. Yet the court of appeals, even while recognizing his outpatient commitment as evidence that mental health clinicians had not deemed him to be a significant risk to the public, ultimately decided that, "the necessary implications of the indictment in this case preclude a finding that Dillon is harmless" (*Dillon*, p 297). As forensic psychiatrists, we are quite familiar with performing risk assessments to determine an individual's risk of self-harm or violence, but for the purpose of a *Sell* hearing, how is dangerousness determined? Is it the function of a mental health evaluation and risk assessment or merely based on the designation of the individual's present charges? The court's ruling in *Dillon* seems to indicate it is the latter, as Mr. Dillon was deemed to be a low risk by mental health providers, yet still dangerous by the court as a function of his charges. This possibility subsequently raises questions as to whether the opposite would be true: could an individual deemed psychiatrically to be at high risk for violence (and perhaps requiring involuntary medication under *Harper*) be found to be nondangerous in a *Sell* hearing if his charges were nonviolent? Clarifying how the court will define dangerousness for the purpose of *Sell* seems prudent, given these potential problems.

Another question raised by *Dillon* is what consideration, if any, should outpatient civil commitment be given as a special circumstance under the first *Sell* factor? *Sell*, by essentially equating inpatient psychiatric commitment to a form of social control, outlines that lengthy confinement in an institution would constitute such a special circumstance, as it would "diminish the risks of freeing without punishment one who has committed a serious crime" (*Sell*, p 180). Outpatient commitment, while not equivalent to confinement in an institution, does provide a degree of oversight and infringement on an individual's civil liberties, as well as the opportunity to initiate psychotropic medications Thus, it may warrant consideration as a special circumstance under *Sell*, though certainly less so than inpatient confinement and perhaps only in cases where there is already some question as to the government's important interest in prosecuting the defendant.

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Sentencing Adjustment Following an Unsuccessful Insanity Defense

James Gusfa, DO
Fellow in Forensic Psychiatry

Maya Prabhu, MD, JD
Assistant Professor of Psychiatry

Division of Law and Psychiatry
Department of Psychiatry
Yale University School of Medicine
New Haven, CT

Downward Adjustment in Sentence Is Not Granted for Confessing to a Crime Before Raising an Insanity Defense

In *United States v. Herriman*, 739 F.3d 1250 (10th Cir. 2014), the Court of Appeals for the Tenth Circuit affirmed a lower court holding that Daniel Herriman was not eligible for a sentence reduction after asserting a failed insanity defense. This case brings attention to the precarious position insanity defendants can find themselves in when not claiming innocence but not admitting guilt.

Facts of the Case

On August 10, 2011, Mr. Herriman planted a bomb near a gas pipeline in Okemah, Oklahoma. Without prompting, he later contacted the police and reported his involvement. He provided police with specific information relating to the bomb's components and manufacture. The government charged him with attempting to destroy or damage property by means of an explosive and with illegally making a destructive device.

Mr. Herriman had an extensive history of psychiatric illness and treatment that reached back to his youth. He was raised within a complicated family environment with a significant family history of mental illness. He experienced symptoms related to trauma, psychosis, and mood instability. During certain periods of his life, he required psychiatric hospitalization. Around the time of the offense, he was taking antipsychotic medication prescribed by a psychiatrist in an outpatient setting.

Mr. Herriman was reportedly experiencing worsening social and emotional stressors leading up to the period when he planted the bomb. The anniversary of his mother's death by suicide was approaching and