tently indicated that Mr. Chase had significant adaptive functioning deficits from an early age. The circuit court found that Dr. Reschly's conclusions about Mr. Chase's behavior were "based largely on personal opinions and moral judgment" (*Chase*, p 483). Mr. Chase had argued that *Goodin* required the trial court to accept the opinions of Dr. Reschly regarding the credibility of these witnesses. However, the Mississippi Supreme Court deferred to the circuit court as the "sole authority for determining credibility of the witnesses" (*Chase*, p 479).

Dr. Macvaugh's testimony was based on a broader review of evaluations and testing, but he did not conduct third-party interviews as part of his evaluation, as he had "sufficient information with which to reach a conclusion on the question of whether Chase was intellectually disabled" (*Chase*, p 487). This was the focus of the third part of Mr. Chase's appeal. Mr. Chase argued that the circuit court should have reopened the proceedings to hear testimony from these third parties, but the Mississippi Supreme Court ruled that the circuit court did not abuse its discretion by denying Mr. Chase's motion for a new trial.

Dissent

Three justices joined in a dissenting opinion that disagreed with the majority's conclusions as to the import and veracity of Dr. Reschly's third-party interviews. The dissent asserted that Dr. Reschly had actually correctly followed the guidelines as to "third party interviews" outlined in *Goodin*. More fundamentally, the dissent opined that the current *Atkins* approach that relies on the mental health community to inform the court is flawed. The dissent asserted that:

> …a person at age thirty, but before his crime, who suffers a brain injury that results in a 60 I.Q. and severe deficits in two or more areas of social function, is currently eligible to be sentenced to death, simply because his mental disability did not manifest prior to age eighteen [*Chase*, p 494].

The dissenters called for a "judicial definition of intellectual disability that meets constitutional concerns" (*Chase*, p 494).

Discussion

The Mississippi Supreme Court did not find that the circuit court erred by finding that Mr. Chase had failed to prove intellectual disability by a preponderance of the evidence. However, the court asserted that, since *Atkins* had left the matter of methods or procedures of intellectual disability determination in capital cases to the states, and since "our Legislature [has] not undertaken that task," the court itself would have to outline such procedures. Citing their own opinion in *Thorson v. State*, 76 So. 3d 667 (Miss. 2011), the court held that for capital defendants to qualify for an *Atkins* defense, they must prove by a preponderance of the evidence that they have significantly subaverage intellectual functioning manifesting before age eighteen, as well as deficits in two or more adaptive skills, and that they are not malingering. The court opined that the trial court had not engaged a "depth of investigation" necessary for assessing intellectual disability for the purposes of *Atkins* (*Chase*, p 486). In reality, in capital case intellectual disability evaluations, in which the defendant's IQ is borderline, as in *Chase*, there is probably no "depth of investigation" sufficient to satisfactorily address the court's concerns. Courts understandably want a concrete, reasonably precise answer in these cases, but in borderline cases, the desire for concrete solutions is misplaced. Although much progress has been made, the current neuroscientific understanding of phenomena such as "functionality" and cognition is limited. The aforementioned standards promulgated for the evaluation of intellectual disability are inherently abstract and lack the precision that courts understandably prefer.

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Forced Medication to Restore Competency

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

In *United States v. Ruark*, 611 F. App'x 591 (11th Cir. 2015) the United States Court of Appeals for the Eleventh Circuit affirmed the district court's decision to medicate an inmate involuntarily with psychotropic medication for the purpose of rendering

him competent to stand trial, relying on the criteria set forth in *Sell v. United States*, 539 U.S. 166 (2003).

Facts of the Case

On April 13, 2010, Mark Joshua Ruark, who had a history of psychiatric hospitalizations, was charged with two robberies, two counts of carrying a firearm during a violent crime, and possession of a firearm by a convicted felon. Immediately after his indictment, Mr. Ruark was taken into federal custody, where he has remained.

During the course of his incarceration, Mr. Ruark expressed numerous unusual beliefs focused on being persecuted by the government. Treaters diagnosed his condition as schizophrenia and offered treatment with antipsychotic medications. Mr. Ruark agreed only to a trial with 80 mg of ziprasidone in March 2011.

In May 2011, Mr. Ruark's defense counsel questioned his competency to stand trial. Following a psychiatric evaluation and a competency hearing in February 2012, Mr. Ruark was found incompetent to stand trial. He was committed to the Medical Center for Federal Prisoners in Springfield, MO, for restoration of competency in April 2012. In the course of the subsequent nine-month commitment, he received voluntary treatment with 80 mg of ziprasidone between May and July, when he stopped, believing that it "weakened his immune system, causing him to catch a cold" (*Ruark*, p 594). He resumed treatment briefly in August 2012.

After Mr. Ruark's refusal of treatment, an administrative hearing was held in September 2012 to determine whether he met the criteria (i.e., dangerousness or grave disability) for involuntary medication under *Washington v. Harper*, 494 U.S. 210 (1990). The hearing officer concluded that Mr. Ruark did not pose a danger to himself or others in a correctional setting, despite his psychotic disorder. Mr. Ruark was discharged from Springfield to U.S. Penitentiary Atlanta in January 2013, where, during the spring and summer, he agreed to treatment with 0.5 mg of risperidone a day.

In February 2013, the government sought authorization for involuntary medication in accordance with *Sell*. At the hearings held in May and November 2013, treaters cited multiple competency restoration studies and testified that 75 to 80 percent of patients with psychotic illness are successfully restored to competency with antipsychotic medications over a period of four to eight months. In February 2014, the magistrate judge authorized use of involuntary medication to restore Mr. Ruark's competency, to which the patient objected. In October 2014, the district court overruled Mr. Ruark's objections and granted authorization for involuntary medication. He subsequently requested a stay of the *Sell* order. In November 2014, he appealed to the United States Court of Appeals for the Eleventh Circuit.

Mr. Ruark first argued that being charged with a federal crime did not automatically presume an important government interest, characterizing his own crimes as "only two 'run-of-the mill' robberies" during which no one was shot or injured (*U.S. v. Ruark*, 2014 U.S. Dist. Lexis 141452, p 21(N.D. Ga. 2014)). He also contended that his lengthy confinement and the prospect of remaining in some form of civil mental health custody for several more years should be considered a special circumstance, as described in *Sell*, which lessens the importance of the government's interest in punishing him.

Second, Mr. Ruark argued that the involuntary medication was not substantially likely to render him competent (under the second *Sell* factor, requiring a "substantial likelihood" that medications will render the defendant competent and will be unlikely to have side effects interfering with ability to assist counsel), given that close to three months of treatment did not result in restoration. Citing the APA's Practice Guideline for the Treatment of Patients with Schizophrenia (Lehman *et al.*, 2004, p 39. Available at http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia.pdf/. Accessed February 6, 2016), Mr. Ruark noted that "10–30 percent of schizophrenic patients have little or no response to antipsychotic medications, and up to another 30 percent have partial responses." He argued that the resultant 40 percent remission rate does not support a finding of "substantial likelihood" of restoration.

Third, Mr. Ruark argued that the proposed treatment was not medically appropriate, as the government failed to establish that there were no less intrusive means of achieving competency. He also objected to treatment with dosages that exceeded Physicians Desk Reference (PDR) recommendations and to any additional period of treatment given his nine-month confinement in Springfield.

Finally, he contended that legal competency does not qualify as a medically appropriate goal of treatment in a forensic hospital. Restoration to legal competency would undercut his medical goals, since a lengthy prison sentence, given conditions in U.S. prisons, would result in overall deterioration of his health. He also objected to dual roles of physicians in forensic institutions who are tasked with both treating inmates and serving as government expert witnesses.

Ruling and Reasoning

The United States Court of Appeals for the Eleventh Circuit reviewed the first *Sell* factor *de novo* and the other three factors for clear error and affirmed the district court's decision based on previous case law from *Sell* and *United States v. Diaz*, 540 F.3d 1316 (11th Cir. 2008).

The court of appeals first addressed whether, in Mr. Ruark's case, special circumstances, such as the prospect of civil commitment or the length of pretrial detention, may lessen the importance of the government interests at stake. Given that the likelihood of Mr. Ruark's commitment was unknown and the crimes with which he was charged were serious, carrying mandatory sentences well in excess of his pretrial detention, the court ruled that the district court did not err in finding important governmental interests at stake.

The court of appeals next ruled that the district court did not err when it relied on its consideration of substantial likelihood on treaters' testimony that 75 to 80 percent of involuntarily medicated inmates are restored to competency. In addition, proposed procedures of close monitoring satisfied the burden of reducing the likelihood of adverse effects of medications.

Third, the court noted that ample evidence was presented that, given the biological basis of schizophrenia, recovery was unlikely in the absence of medications.

Finally, the court of appeals ruled that the administration of antipsychotic medication is medically appropriate considering Mr. Ruark's medical condition. As to his objection to a potential treatment with higher medication doses, the court relied on treaters' testimony that any dosage beyond the range described in the PDR reflects learned experience of the medical community.

Discussion

Inmates with mental disabilities do not automatically lose their right to refuse the imposition of treatment. There are several mechanisms for delineating rules for involuntary medication to inmates, including administration in life-threatening situations and when an inmate poses a threat of danger to self or others or is gravely disabled, as outlined in *Harper*. *Sell* outlines procedures for involuntary medication of incompetent inmates who present no risk of danger to self or others and are not gravely disabled. However, existing mechanisms do not necessarily account for all potential complications for individuals committed to forensic hospitals as incompetent to stand trial (IST). Unlike individuals hospitalized after civil commitment or a successful insanity defense, the IST population continues to be involved in active criminal proceedings in which trial strategizing may play a role in treatment refusal.

The *Ruark* case illustrates several such problems. The court of appeals did not find merit in Mr. Ruark's contention that his lengthy confinement and prospect of remaining in some form of civil mental health custody for several more years should constitute a special circumstance. However, in its discussion of special circumstances in *Sell*, the Supreme Court outlined that the "defendant's failure to take drugs voluntarily . . . may mean lengthy confinement in an institution for the mentally ill—and that would diminish the risks that ordinarily attach to freeing without punishment one who has committed a serious crime" (*Sell*, p 180). Although not explicitly stated as such, *Sell* essentially equates inpatient psychiatric commitment to a form of social control or punishment. In addition, the Supreme Court did not distinguish between confinement to a forensic hospital and the ability to administer medically appropriate treatment, creating the prospect of lengthy, yet noneffective commitments. It is not clear why the Court found that psychiatric hospitalization could be considered a reasonable substitution for criminal punishment. This idea, however, is troubling for forensic psychiatrists who provide care in such hospitals. Further, delays in the authorization of treatment and resolution of the question of competence to stand trial create the potential that persons will experience long periods of untreated psychosis that would otherwise be addressed through civil proceedings.

Mr. Ruark also raised the intriguing challenge to the government to prove that competence restora-

tion is itself a medically appropriate goal. He argued that the conditions in American prisons are such that restoration to legal competence may not be in a defendant's best medical interests. The Eleventh Circuit took a more traditional approach to the subject of medical appropriateness and did not discuss the merits of the broader sociological argument that potentially challenges the ethics of forensic practice in facilities charged with treating individuals to restore competence to stand trial.

That ethics concern is addressed in the AAPL Ethical Guidelines: "Psychiatrists in a forensic role are called upon to practice in a manner that balances competing duties to the individual and to society. In doing so, they should be bound by underlying ethical principles of respect for persons, honesty, justice, and social responsibility (American Academy for Psychiatry and the Law Ethics Guidelines for the Practice of Forensic Psychiatry Adopted May 2005, p 1).

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