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# A New Twist in the War on Drugs: The Constitutional Right of a Mentally Ill Criminal Defendant to Refuse Antipsychotic Medication That Would Make Him Competent to Stand Trial

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**A NEW TWIST IN THE WAR ON DRUGS: THE CONSTITUTIONAL  
RIGHT OF A MENTALLY ILL CRIMINAL DEFENDANT TO REFUSE  
ANTIPSYCHOTIC MEDICATION THAT WOULD MAKE HIM  
COMPETENT TO STAND TRIAL**

I. INTRODUCTION .....273  
 II. MENTAL COMPETENCY IN CRIMINAL PROCEEDINGS .....278  
 III. THE CASE AGAINST A RIGHT TO REFUSE ANTIPSYCHOTIC  
 MEDICATION TO ATTAIN COMPETENCE TO STAND TRIAL ...279  
 IV. THE ARGUMENTS SUPPORTING A RIGHT TO REFUSE  
 ANTIPSYCHOTIC MEDICATION EVEN WHERE THE  
 MEDICATION RESULTS IN COMPETENCY TO STAND TRIAL ..293  
 V. ADDITIONAL CONCERNS WITH FORCIBLY MEDICATING A  
 MENTALLY ILL DEFENDANT TO ATTAIN COMPETENCY  
 TO STAND TRIAL .....301  
 VI. ALTERNATIVES TO FORCIBLE MEDICATION TO ATTAIN  
 COMPETENCY TO STAND TRIAL .....303  
 VII. CONCLUSION.....306

I. INTRODUCTION

Much controversy has accompanied the forced use of antipsychotic drugs on civilly committed mental patients, where the drugs are used to regain mental health, and on mentally ill criminal defendants, where the drugs are used to attain competency to stand trial.<sup>1</sup> Legal scholarship has discussed the dangerous side effects which antipsychotic medications often produce, effects which occur even where the drugs are responsibly administered with great care for the patient.<sup>2</sup> The interest of a patient/defendant in avoiding the potential adverse side effects of antipsychotic drugs may be in conflict with the asserted state interests in forcible medication: management of the mentally ill and restoring competency to stand trial. The American Psychiatric Association supports forcible medication as a method of treatment that has been proven highly effective and often essential for patients requiring involuntary psychiatric hospitalization.<sup>3</sup> Within the judicial system, there has been clear disagree-

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<sup>1</sup> Antipsychotic drugs are also known as neuroleptics and major tranquilizers. The term "antipsychotic" will be used throughout this Note. Antipsychotic medications are a subclass of psychotropic medications - drugs used in treating psychiatric problems - and are known to the lay person by their brand names, such as Thorazine, Prolixin, Haldol, Stelazine, and Navane. See generally Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 179 (1980) [hereinafter *Antipsychotic Medication*].

<sup>2</sup> *Id.* at 183-88.

<sup>3</sup> Brief of American Psychiatric Association at 6, *Mills v. Rogers*, 457 U.S. 291 (1982). See also ABA CRIMINAL JUSTICE MENTAL HEALTH STANDARDS 7-4.10 (1989) [hereinafter MENTAL HEALTH STANDARDS]. The APA believes that even a qualified right to refuse treatment places mental health professionals in the difficult position for being responsible for patients who as a result of refusal may receive improper or inadequate treatment. For a description of the most recent APA guidelines for nonjudicial review where a patient refuses antipsychotic medication, see *Review Procedure for Medication Refusal Cases*, *Psychiatric News*, Feb. 2, 1990, at 5, col. 1 (provision is made for a psychiatrist from outside the treating facility, appointed by the director of the facility, to determine whether the medication is necessary and, optionally, whether the patient is incompetent to consent; no judicial involvement is contemplated).

ment on the issue of forcibly administering antipsychotic medication.<sup>4</sup> Even among psychiatric professionals there remains a deep schism between those who follow the Freudian psychodynamic model of mental illness<sup>5</sup> which logically rejects forcible medication, and biologically oriented psychiatrists whose medical model embraces drug therapy as the treatment of choice.<sup>6</sup>

The purpose of this Note is to analyze what right, if any, exists for a mentally ill criminal defendant to refuse the administration of antipsychotic drugs to gain competence to stand trial. Focusing mainly on the trial context of the right to refuse is not to suggest that there is not overlap between the right of a criminal defendant to refuse and the right of a civilly committed patient to refuse. Indeed, it is often unclear why an individual is brought to the emergency room of a general hospital and eventually committed, rather than being arrested and booked and later found incompetent to stand trial.<sup>7</sup> The constitutional analysis of the right of a mentally ill defendant to refuse antipsychotic drugs is informed by the existence of a similar right in the civil commitment area, although the state interests in these two areas differ; while the state interest in forcibly medicating a defendant for the purpose of standing trial is that

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<sup>4</sup> For two recent decisions, see *Jarvis v. Levine*, 418 N.W. 2d 139 (Minn. 1988) and *United States v. Charters*, 863 F.2d 302 (4th Cir. 1988). In *Jarvis*, the supreme court of Minnesota held that the involuntary administration of antipsychotic medication to an involuntarily committed, mentally ill patient in a nonemergency situation constituted intrusive treatment and required prior judicial approval. In *Charters*, the fourth circuit gave wide latitude to the Federal Correction Institution to administer antipsychotic drugs forcibly where one of the governmental interests was to maintain a pretrial detainee in a competent condition to stand trial.

<sup>5</sup> This branch of psychiatry stresses verbal psychotherapy and has influenced some in the judiciary to automatically bar the use of drugs while a defendant is on trial. Winick, *Psychotropic Medication and Competence to Stand Trial*, 3 AM. B. FOUND. RES. J. 769, 790 (1977).

<sup>6</sup> However, even the medical supporters admit that the antipsychotic drugs sometimes inadvertently have powerful side effects. The most notorious of these is tardive dyskinesia, manifested by grotesque movements of the face, tongue, mouth and limbs. For many patients this condition is irreversible and has no known cure. See *Antipsychotic Medication*, *supra* note 1, at 185. Its cause is unknown beyond that it is a common reaction to protracted use of antipsychotic drugs. Some estimates claim that it affects over fifty percent of long-term antipsychotic drug users. See Note, *A Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill*, 82 COLUM. L. REV. 1720, 1726 n. 66 (1982). "One does not need a medical degree to realize we are not discussing aspirin." *Jones v. Gerhardstein*, 141 Wis. 2d 710, 726, 416 N.W. 2d 883, 890 (1987) (holding that although incompetent to stand trial, if an individual is competent to make decisions regarding the acceptance of antipsychotic drugs he cannot be forcibly administered them).

<sup>7</sup> Whether a person becomes labelled a criminal or a mental patient at the outset may be due in large part to a decision made by a police officer. For a discussion on the difference the classification makes, see Steadman, *Mental Health Law and the Criminal Offender: Research Directions For The 1990's*, 39 RUTGERS L. REV. 323 (1987). See also Note, *Just Say Yes: The Fourth Circuit (En Banc) Denies Pretrial Detainee's Right to Refuse Psychotropic Medication in United States v. Charters*, 12 GEO. MASON U. L. REV. 117 n.2 (1990).

of trying those accused in good faith of violating its laws, the interests in coercing antipsychotic drug treatment in the civil commitment area are patient control, treatment, and fiscal concerns.<sup>8</sup> This Note first analyzes the relationship between competency and ability and then presents the arguments supporting the view that a defendant should have no meaningful right to refuse medication. After presenting the legal analysis supporting the right to refuse antipsychotic drugs in the trial setting, the Note proceeds to consider several possible alternatives to forced drugging as a means toward achieving the state's goal of a fair trial and concludes that these alternatives, while arguably less effective than medication, are preferable to forced drugging since they more adequately address the legitimate concerns of both the state and the mentally ill criminal defendant.

Unfortunately, the issue of the right to refuse antipsychotic medication has not yet been directly addressed by the Supreme Court. In the 1982 case, *Mills v. Rogers*,<sup>9</sup> the Court granted certiorari on the very issue of whether an involuntarily committed mental patient has a constitutional right to refuse treatment with antipsychotic drugs in a non-emergency situation. However, the Court sidestepped the constitutional issues raised by *Mills* by remanding the case to the First Circuit Court to consider how an intervening state case may have changed the state law.<sup>10</sup> In its 1985 decision in *Ake v. Oklahoma*,<sup>11</sup> the Court held that due process requires that a state provide access to a psychiatrist's assistance on the issue of sanity at the time of an offense where sanity is likely to be a significant defense for an indigent defendant. Although *Ake* petitioned for a writ of certiorari on the issue of his competence to stand trial while being administered antipsychotic drugs, the Court purposely failed to address this claim.<sup>12</sup> There has been optimism that the Supreme Court would finally

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<sup>8</sup> See *infra* note 187 and accompanying text.

<sup>9</sup> 457 U.S. 291 (1982).

<sup>10</sup> The intervening state case was *In re Roe*, 383 Mass. 415, 421 N.E. 2d 40 (1981) which held that a noninstitutionalized, mentally incompetent patient had a right to a judicial hearing at which he could assert his refusal to treatment with antipsychotic drugs. The *Mills* case saw its ultimate resolution in *Rogers v. Commissioner of Dept. of Mental Health*, 390 Mass. 489, 458 N.W. 2d 308 (1983), which held that in a nonemergency situation, no state interest is sufficiently compelling to overcome a patient's decision to refuse. If a patient is found competent, he cannot be forced to take or continue to take antipsychotic medication; if he is found to be incompetent, a judicial substituted judgment treatment plan must be implemented. Massachusetts is at the forefront of enforcing a right to refuse with judicial intervention; perhaps surprisingly, the scheme is working. See Schmidt & Geller, *Involuntary Administration of Medication in the Community: The Judicial Opportunity*, 17 BULL. AM. ACAD. PSYCHIATRY & L. 283 (1989).

<sup>11</sup> 470 U.S. 68 (1985).

<sup>12</sup> *Id.* at 74 n.2. Although it is not clear from the case whether *Ake* voluntarily submitted to Thorazine treatment, the Court could have subjected the issue of drug induced competence to constitutional analysis. The state interest to induce "synthetic competence" would be present in a right to force such competency.

address the constitutional right to refuse issue with its granting of certiorari in the 1988 case of *Harper v. State*.<sup>13</sup> In *Harper*, the Supreme Court of Washington held that a convicted prisoner had a protected liberty interest in refusing antipsychotic drugs and that a judicial hearing was

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<sup>13</sup> 110 Wash. 2d 873, 759 P.2d 358 (1988), *cert. granted*, Washington v. Harper, 109 S. Ct. 2445 (1989). The Supreme Court's opinion in this case was announced on February 27, 1990, in *Washington v. Harper*, 110 S. Ct. 1028 (1990). The Court finally explicitly recognized the possession of a significant liberty interest under the Due Process Clause of the Fourteenth Amendment in avoiding the unwanted administration of antipsychotic drugs. *Id.* at 1036. However, in a 6-3 decision, the majority held that the standard for determining the validity of the prison regulation at issue in *Harper* was whether coercively medicating Harper was reasonably related to legitimate penological interests. *Id.* at 1038. The Court reasoned that since Harper posed a serious danger to the security of the prison and had failed to demonstrate that physical restraints or seclusion would be acceptable substitutes for the medical effectiveness of antipsychotic drugs (an effect which, the Court emphasized, was also in the inmate's medical interest), forcible medication in this case did not violate the Constitution. *Id.* at 1040. Thus, the Court adopted the low level of scrutiny of the "reasonably related" test even for a fundamental liberty right, since it was defining that right in the context of an inmate's confinement. *Id.* at 1037. Although the opinion did not state as much, its decision not to require a judicial rather than an institutional hearing to protect Harper's procedural rights apparently flows from the low level of scrutiny used to decide the substantive issue. *Id.* at 1040-44. Justice Stevens, writing for the dissent, emphasized the severe deprivation of liberty that mind-altering drugs represent and made reference to comparisons with electroconvulsive therapy and psychosurgery. *Id.* at 1047. The dissent correctly observed that the majority's assumption that drug treatment was in the inmate's medical interest was at best weak and at worst false - the policy at issue in *Harper* did not require a determination that forced medication would advance the inmate's medical interests. *Id.* at 1049 n.11. Impliedly, the dissent would have required a stricter level of constitutional scrutiny to protect the substantive liberty right at stake. Furthermore, the dissent described the lack of procedural due process inherent in an in-house institutional review: this system "pits the interests of an inmate who objects to forced medication against the judgment not only of his doctor, but often his doctor's colleagues." *Id.* at 1052. "The choice is not between medical experts on the one hand and judges on the other; the choice is between decision makers who are biased and those who are not." *Id.* n.20.

The implications of the *Harper* decision are not entirely clear. The majority decision may be read narrowly as another in a series of prison cases which extend weaker versions of fundamental rights to prisoners than enjoyed by non-prisoners. *Id.* at 1037. Given a narrow interpretation, *Harper* could be used to support a strong right to refuse antipsychotic drugs by a defendant not otherwise competent to stand trial or by a civilly committed mental patient. Conversely, the great deference shown by the majority to medical review and the assumption that a medical decision is in the prisoner's best medical interest (and not mainly or only for institutional control purposes) may be interpreted to support forced drugging and non-judicial review outside the prison context. Unfortunately, the *Harper* decision leaves many of the questions in the non-prison situation without direct answers. Indeed, the decision is probably deserving of a Note unto itself to fully work through all the possibilities.

<sup>14</sup> The case holding is somewhat unique in that it required a judicial hearing even though *Harper* was found to be a danger to others, 110 Wash. 2d at 875, 759 P.2d at 360. Other right to refuse cases have held that where a danger exists, the liberty interest is outweighed by the state's legitimate objective to achieve behavior acceptable to a safe society. See *Dautremont v. Broadlawn Hosp.*, 827 F.2d 291 (8th Cir. 1987). See *supra* note 13.

required before he could be forcibly medicated.<sup>14</sup>

Prior to *Harper*, the closest the Court has come to discussing the issue of forced therapeutic treatment was in the 1982 case of *Youngberg v. Romeo*.<sup>15</sup> The plaintiff, Romeo, was a retarded man who had been institutionalized since childhood and sued the officials of a Pennsylvania state institution for damages relating to violations of his liberty interests in safe conditions of confinement and freedom from undue bodily restraint.<sup>16</sup> The relevance of *Romeo* on the issue of forcible medication is that the Court held that even an individual subject to involuntary control by the state retains a residuum of liberty that is protected by the Fourteenth Amendment.<sup>17</sup> The *Romeo* Court adopted a low level of scrutiny to determine whether a patient's liberty rights had been unconstitutionally violated; only where the treatment decision was "such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person did not base the decision on such a judgment" could liability be imposed.<sup>18</sup> Since the problems associated with care of the mentally retarded may differ in many ways from those associated with care of the mentally ill, it might therefore appear unclear as to whether the decision in *Romeo* should control the right of the mentally ill to refuse antipsychotic medication. In spite of this observation, the Supreme Court nevertheless vacated two other right to refuse antipsychotic drug cases to be decided in light of *Romeo*.<sup>19</sup> On remand, the application of *Romeo*'s professional judgment standard effectively altered the definition of the constitutional right to refuse antipsychotic medication by a competent and non-dangerous mental patient in a non-emergency situation from literally preventing medication administration to a

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<sup>15</sup> 457 U.S. 307 (1982).

<sup>16</sup> *Id.* at 319.

<sup>17</sup> *Id.*

<sup>18</sup> *Id.* at 323. This standard is basically the same as that used in malpractice claims.

<sup>19</sup> *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981), *vacated*, 102 S. Ct. 3506 (1982); *Scott v. Plante*, 641 F.2d 117 (3d Cir. 1981), *vacated*, 458 U.S. 1119 (1982). See Perlin, *Can Mental Health Professionals Predict Judicial Decision Making? Constitutional and Tort Liability Aspects of the Right of the Institutionally Mentally Disabled to Refuse Treatment: On the Cutting Edge*, 3 *TUORO L. REV.* 13, 21 (1986). An even more fundamental distinction between *Romeo* and the right to refuse medication cases is that *Romeo* was, in effect, a right to treatment case where the Court held that the state was required to provide Romeo with minimally adequate or reasonable training to ensure safety and freedom from undue restraint. There is a critical difference between the affirmative interference with rights by the state through forcible medication of a patient/defendant and the duty of the state, dealt with in *Romeo*, to take positive actions to promote rights.

right to object or to a second opinion.<sup>20</sup> It should be noted that *Romeo* involved no allegation that a judicial hearing was required prior to enforced treatment. Much of the significance of *Harper* is that the issue of the constitutional right to refuse is framed precisely in terms of a right to judicial review, a right which would put some substance into the liberty protection that mental patients supposedly enjoy.<sup>21</sup>

## II. MENTAL COMPETENCY IN CRIMINAL PROCEEDINGS

Originally, the requirement that a defendant be competent in order to stand trial was based on the concept of procedural fairness.<sup>22</sup> The competency doctrine had its origins in mid-seventeenth century England where counsel was prohibited in serious criminal cases and the defendant was required to appear before the court and conduct his defense in his own words.<sup>23</sup> Consequently, during this period, it was critical to have a competent defendant, for he alone conducted the defense. The procedural fairness rationale was followed in the United States in the early cases of *Youtsey v. United States*<sup>24</sup> and *United States v. Chisolm*.<sup>25</sup> More recent opinions base the competency requirement on the due process clause of the Constitution and derive it from the common law prohibition against trials *in absentia*.<sup>26</sup>

What is the standard of competency below which a proceeding is unfair and violates due process? The sixth circuit in *Youtsey* reversed the conviction of a defendant because the trial court had failed to inquire as to whether epileptic seizures had rendered him "incapable of understanding the proceedings, and intelligently advising with his counsel as to his defense."<sup>27</sup> The *Chisolm* decision held that a defendant may stand trial in a criminal case "if he rightly comprehends his own condition with reference to the proceedings" and is able to "testify intelligently and give

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<sup>20</sup> See Brooks, *The Right to Refuse Antipsychotic Medications: Law and Policy*, 39 RUTGERS L. REV. 339 (1987). On remand, in *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983), the third circuit, in light of *Romeo*, upheld New Jersey's treatment procedures, which provided a review system that simply required a treating doctor to seek the approval of his treatment team for enforced medication.

<sup>21</sup> It is unclear what effect, if any, recognition by the Supreme Court of a right to a judicial hearing on the issue of forced medication would have for a criminal defendant asserting the right to avoid coerced competence; in the trial setting the decision to medicate would probably already involve a judicial determination to proceed with enforced drugging or judicial notice that a defendant was only competent to stand trial while on antipsychotic drugs.

<sup>22</sup> See generally R. ROESCH & S. GOLDING, *COMPETENCY TO STAND TRIAL* (1980).

<sup>23</sup> See 4 W. BLACKSTONE, *COMMENTARIES ON THE LAWS OF ENGLAND* 94 (4th ed. 1783). This prohibition against the assistance of counsel continued in felony and treason cases for centuries.

<sup>24</sup> 97 F. 937, 941 (6th Cir. 1899).

<sup>25</sup> 149 F. 284, 287 (C.C.S.D. Ala. 1906).

<sup>26</sup> See *Drope v. Missouri*, 420 U.S. 162 (1975); *Pate v. Robinson*, 383 U.S. 375 (1966). Incompetence to stand trial is viewed as removing a defendant from being meaningfully present at the proceedings.

<sup>27</sup> 97 F. 937 at 946.

his counsel all the material facts" in the case.<sup>28</sup> Based on the common law "understand and assist" standard of mental competency articulated in *Youtsey* and *Chisolm*, the Supreme Court formulated the current standard in the 1960 case of *Dusky v. United States*,<sup>29</sup> the seminal decision on the definition of competency to stand trial. The Court in *Dusky* stated that the "test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and whether he has a rational as well as factual understanding of the proceedings against him."<sup>30</sup> *Dusky* is significant in that the Court held that a defendant needed to be able to do more than identify facts; he must have some capacity to reason from a simple premise to a simple conclusion.<sup>31</sup>

The standard articulated in *Dusky* for competence to stand trial is obviously not the same standard that a mental health professional would use to describe mental health; "mental health" describes a higher level of competence than competency to stand trial requires.<sup>32</sup> It is also clear that while a defendant may fall short of the requirements needed to be competent to stand trial, he can still be competent enough to know that he likes certain foods and is adversely affected by certain drugs and even competent enough to intelligently refuse medication whose positive effect is the attainment of the *Dusky* triability level.

### III. THE CASE AGAINST A RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION TO ATTAIN COMPETENCE TO STAND TRIAL

The *ABA Criminal Justice Mental Health Standards*<sup>33</sup> recognizes no meaningful right to refuse drug treatment to attain competency to stand trial; on the contrary, a duty to undergo treatment to achieve a mental state compatible with competency for trial is strongly implied:<sup>34</sup>

A person determined to be incompetent to stand trial and detained or committed for treatment or habilitation or ordered to appear for outpatient treatment or habilitation should have no right to refuse ordinary and reasonable treatment or ha-

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<sup>28</sup> 149 F. 284 at 287.

<sup>29</sup> 362 U.S. 402 (1960).

<sup>30</sup> *Id.*

<sup>31</sup> The Court disagreed with the trial judge's belief that if the defendant could recognize "2" as "2" then it was not necessary that he be able to add "2 + 2" and arrive at a total of "4." See Haddox, Gross & Pollack, *Mental Competency to Stand Trial While Under the Influence of Drugs*, 7 LOYOLA L. REV. 425, 435-36 (1974).

<sup>32</sup> For example, a defendant may meet the *Dusky* standard for competence to stand trial, but may still suffer from delusions, may be manic-depressive, or irresponsible, etc.

<sup>33</sup> See MENTAL HEALTH STANDARDS, *supra* note 3, at 7-4.10(d). The ABA House of Delegates adopted the *Mental Health Standards* as chapter seven of the ABA STANDARDS FOR CRIMINAL JUSTICE on August 7, 1984.

<sup>34</sup> *Id.*



bilitation designed to effect competence. However, a defendant should have the right to refuse any treatment or habilitation which may impair the defendant's ability to prepare a defense to the charge, which is experimental, or which has an unreasonable risk of serious, hazardous or irreversible side effects.<sup>35</sup>

While *Mental Health Standards* maintains that defendants committed as incompetent to undergo criminal trial proceedings are unable to refuse treatment that may restore or attain competence for trial, a right to refuse is recognized where competence for trial is not an issue.<sup>36</sup>

An offender who has been placed in a mental health or mental retardation facility has the same right to decline habilitation or mental health treatment as a civilly committed person in that jurisdiction.<sup>37</sup>

In addition, even a prisoner involuntarily transferred to a mental health or mental retardation facility is afforded the same right to refuse treatment as a civilly committed person in the jurisdiction.<sup>38</sup> What would explain the recognition of some right to refuse treatment except where the goal is competence for trial? Why is an incompetent detainee's liberty interest in freedom from bodily intrusiveness more easily compromised than the liberty interest of a prisoner or civilly committed patient?

The state's interests in subjecting its citizens to treatment without their consent have been recognized in case law as falling into two distinct categories: those arising from the state's authority to act as *parens patriae* and those arising from the state's police power.<sup>39</sup> The *parens patriae* obligation of the state is a doctrine which speaks to the welfare of the state's citizenry as individuals. In the mental health context, the doctrine mandates treatment for those who require it and it requires respect for the wishes of those who decline medication. The claim to reject treatment or habilitation under other than emergency circumstances rests on the presumption that treatment is primarily, if not exclusively, for the benefit of the convict/patient, not for the benefit of the criminal justice system. Use of the *parens patriae* doctrine to force medication with antipsychotic drugs generally rests upon a determination that the individual to whom the drugs are to be administered lacks the capacity to decide for himself whether to take the drugs.<sup>40</sup> The state, under *parens patriae* logic, is

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<sup>35</sup> *Id.*

<sup>36</sup> *Id.* 7-9.12, 7-10.9.

<sup>37</sup> *Id.* 7-9.12. This section of the *Mental Health Standards* concerns convicts who are committed to mental health facilities because of severe mental illness or to mental retardation facilities due to severe mental retardation; it does not concern detainees awaiting trial.

<sup>38</sup> See *MENTAL HEALTH STANDARDS*, *supra* note 3, at 7-10.9.

<sup>39</sup> *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983); *Rennie v. Klein*, 462 F.Supp. 1131, 1145 (D.N.J. 1978).

<sup>40</sup> *Winters v. Miller*, 446 F.2d 65, 81 (2d Cir. 1971), *cert. denied*, 404 U.S. 985 (1971). In *Winters*, the second circuit held that a competent, involuntarily admitted mental patient stated a claim under 28 U.S.C. §1343 (3)(1969) and 42 U.S.C. §1983 (1969) for having been medicated despite her religious objection. In so holding, the court observed that the state's *parens patriae* powers could not be used to force treatment without a judicial determination of incompetency. 446 F.2d at 71. Involuntary commitment of non-dangerous persons unable to survive in freedom may also be predicated on the *parens patriae* power of the state.

looking out for the incompetent's welfare, not just the welfare of the state or of society as a whole. Since the *parens patriae* doctrine would support a right to refuse forced antipsychotic medication unless a mentally ill defendant is so incompetent as to be unable to intelligently assert a refusal, the doctrine cannot be the source for the position of the *Mental Health Standards* in denying a right to refuse where only incompetence to stand trial is at issue.

Although the use of the police power doctrine has been seriously attacked as a basis to forcibly medicate psychiatric patients,<sup>41</sup> the premise has added cogency in the context of achieving competence to be tried for a crime. There is case law precedent employing police power to assert state interests in enforcing justice or preventing health hazards. The Supreme Court in 1966<sup>42</sup> held that the state's police power in gathering evidence of a crime was sufficient to authorize forced extraction of blood from a driver to determine whether he was driving while intoxicated. In 1976, the D.C. circuit court<sup>43</sup> held that the state's police power interest in gathering evidence of a crime was sufficient to authorize involuntary surgical removal of a bullet from a defendant's arm. These two cases illustrate examples of situations in which the state's substantial interest in the integrity of its criminal justice system has outweighed a private interest in freedom from bodily intrusion.<sup>44</sup>

The state's substantial interest in bringing to trial defendants accused in good faith was recognized by the Supreme Court in the 1970 case of *Illinois v. Allen*.<sup>45</sup> In describing that interest, the Court stated that "government has a sovereign prerogative to put on trial those accused in good faith of violating valid laws. Constitutional power to bring an accused to trial is fundamental to a scheme of 'ordered liberty' and prerequisite to social justice and peace."<sup>46</sup> Thus, even assuming the existence of a constitutional right to refuse antipsychotic medication, the state interests

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<sup>41</sup> For psychiatric patients, the police premise, which is the dangerous potential for violence thought to be common to all unmedicated psychotic patients, has been contradicted by psychiatric research. Two hospitals that were required to implement rules including a limited right to refuse antipsychotic medication did not see any significant increase in violent incidents. See Note, *supra* note 6, at 1741 n.185.

<sup>42</sup> *Schmerber v. California*, 384 U.S. 757 (1966).

<sup>43</sup> *United States v. Crowder*, 543 F.2d 312 (D.C. Cir. 1976).

<sup>44</sup> The right to refuse treatment that involves antipsychotic drugs has been based on the right to privacy, the prohibition against cruel and unusual punishment, the right to mental and bodily integrity, and substantive due process. See, e.g., *Mackey v. Procnier*, 477 F.2d 877, 878 (9th Cir. 1973) (the integrity of one's mental processes); *Davis v. Hubbard*, 506 F.Supp. 915, 929-30 (N.D. Ohio 1980) (substantive due process affords right to refuse treatment with antipsychotic drugs); *Souder v. McGuire*, 423 F.Supp. 830, 832 (M.D. Pa. 1976) (cruel and unusual punishment and the right to privacy); *In re Boyd*, 403 A.2d 744, 748 n.8 (D.C. 1979) (privacy interests, citing *Roe v. Wade*, 410 U.S. 113 (1973), and integrity of mental processes, citing *Mackey*).

<sup>45</sup> 397 U.S. 337, 347 (1970) (Brennan, J. concurring).

<sup>46</sup> *Id.*

in competency in order that a trial may take place may count as sufficiently compelling to outweigh the defendant's liberty or privacy interest in avoiding forcible medication.<sup>47</sup> The state's compelling interest in the integrity of its criminal justice system is what sets the right to refuse in the trial situation apart from the right to refuse in the mental health care situation; in the former, the beneficiary of the policy to medicate is seen as being the state, whereas in the latter, public policy is more concerned with the welfare of the committed patient or convict. Ensuring that a defendant is competent, albeit through coerced medication, enhances the integrity of the criminal justice system by placing a primary emphasis on the accuracy of the trial.<sup>48</sup> The goal of accuracy requires that a defendant have a rational understanding of the proceedings against him in order that he may be able to evaluate what facts are relevant to the proof of his innocence.<sup>49</sup> As the Supreme Court succinctly phrased the matter in *Ake v. Oklahoma*,<sup>50</sup> "[t]he private interest in the accuracy of a criminal proceeding that places an individual's life or liberty at risk is almost uniquely compelling."<sup>51</sup> The state also has a powerful interest in a trial's accuracy in order to preserve respect for the trial system, especially where the accused may be sentenced to death or life imprisonment.<sup>52</sup>

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<sup>47</sup> In *Jacobson v. Massachusetts*, 197 U.S. 11, 26-27 (1905), the Court upheld compulsory vaccination to prevent epidemics over the petitioner's due process claim that such a requirement was hostile to the inherent right of the individual to care for his own body and health in such way as would seem best to him. The *Jacobson* opinion, while admitting that there is a sphere within which the individual may assert the supremacy of his own will and rightfully dispute the authority of any human government to interfere with the exercise of that will, still found that:

The liberty secured by the Constitution of the United States . . . does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good. . . . The possession and enjoyment of all rights are subject to such reasonable conditions as may be deemed by the governing authority of the country essential to the safety, health, peace, good order, and morals of the community. Even liberty itself, the greatest of all rights, is not unrestricted. . . . It is . . . liberty regulated by law.

*Id.* at 26-7; see also Winick, *supra* note 5, at 812 n.238.

<sup>48</sup> Note, *Incompetency to Stand Trial*, 81 HARV. L. REV. 454 (1967). Unfortunately, for purposes of constitutional analysis, cases and commentary tend to make the assumption that the state's substantial interest in trying an accused is compelling, while they fail to question what makes that interest compelling as opposed to merely important. Perhaps the compelling nature of the interest in trying an accused should vary with the crime. For example, an accused murderer could be forcibly medicated to stand trial but not an embezzler. In order to prevent the government from forcibly medicating one accused of a minor offense, a clearer examination of what makes the interest in trying those accused of breaking its laws compelling is extremely important.

<sup>49</sup> *Dusky v. United States*, 362 U.S. 402 (1960).

<sup>50</sup> 470 U.S. 68 (1985).

<sup>51</sup> *Id.* at 78.

<sup>52</sup> Because this Note discusses the issue of forcing a mentally ill defendant to attain the *Dusky* standard of competence for trial through the use of antipsychotic drugs, the issue of forced drugging to control misbehavior to protect the dignity and decorum of the trial is beyond the scope of the present discussion.

It is also possible that by not recognizing a right to refuse antipsychotic drugs used to achieve trial competency (other than experimental or unreasonably risky ones), the *Mental Health Standards* sought to avoid the abuse by criminal defendants of the competency process. At one time, a defendant found mentally incompetent to stand trial was committed to a mental hospital or treatment facility until it was determined that he had attained the capacity to proceed. If the requisite capacity was never attained, the commitment had the equivalent effect of a life sentence.<sup>53</sup> In the 1972 Supreme Court decision of *Jackson v. Indiana*,<sup>54</sup> which has been described as the most important mental health care case decided in the 1970's,<sup>55</sup> the old regimen of committing incompetent criminal defendants was laid to rest. In a unanimous decision written by Justice Blackmun, the Court held that the indefinite commitment of a mentally incompetent criminal defendant violated the constitutional principles of equal protection and due process.<sup>56</sup> Substantive due process requires that both the duration and nature of confinement for incompetency bear a reasonable relation to its purpose. The Court said in *Jackson* that a criminal defendant who is committed because of his inability to meet the *Dusky* standard of competence for trial cannot be held more than the period needed to determine whether there is "a substantial probability that he will attain the capacity in the foreseeable future."<sup>57</sup> If it is determined that there is a probability the defendant will soon be able to proceed, his continued commitment needs to be justified by progress toward achieving competence for trial. Incompetent defendants for whom there is no substantial probability of a restoration to *Dusky* competency in the foreseeable future are either to be released or committed under civil commitment statutes.<sup>58</sup>

In the aftermath of *Jackson*, it became increasingly attractive for incompetent criminal defendants, especially those with serious felony

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<sup>53</sup> See Engelberg, *Pre-Trial Criminal Commitment to Mental Institutions: The Procedure in Massachusetts and Suggested Reform*, 17 CATH. U. L. REV. 163, 165 (1967) (twenty-four year old man charged with vagrancy committed as incompetent until his death sixty-three years later); Hess & Thomas, *Incompetence to Stand Trial: Procedures, Results and Problems*, 119 AM. J. PSYCH. 713, 716 (1963) (man accused of gross indecency in 1926 still hospitalized as incompetent in 1963); Parker, *California's New Scheme for the Commitment of Individuals Found Incompetent to Stand Trial*, 6 PAC. L. J. 484, 485 (1975); see also Note, *supra* note 48.

<sup>54</sup> 406 U.S. 715 (1972).

<sup>55</sup> See Steadman, *supra* note 7, at 329.

<sup>56</sup> 406 U.S. at 723-39.

<sup>57</sup> *Id.* at 738.

<sup>58</sup> *Id.* At least one commentator suggested in the aftermath of *Jackson* that even an incompetent defendant per the *Dusky* standard should have the opportunity to litigate the issue of his guilt and that special procedural rules should be used to compensate for his incapacities. See Burt & Morris, *A Proposal for the Abolition of the Incompetency Plea*, 40 U. CHI. L. REV. 66, 85 n.78 (1972). Such a scheme has impliedly been rejected in MENTAL HEALTH STANDARDS, *supra* note 3, at 7-4.10(d) presumably because due process would not be satisfied if the defendant lacks the *Dusky* ability to relate to the proceedings.

charges facing lengthy prison terms, to be found permanently incapacitated so as to gain the benefits of *Jackson*.<sup>59</sup> Frequently, the charges against those deemed permanently incapacitated were dismissed;<sup>60</sup> alternately, such defendants were processed under state civil commitment statutes with more liberal release standards than a criminal sentence.<sup>61</sup> It is therefore not surprising that after *Jackson* one district court judge wrote that he was aware of many criminal cases where the defendants made apparently miraculous recoveries after pending criminal charges were dropped because of a determination that the defendant would not soon regain competency to be tried.<sup>62</sup> The post-*Jackson* abuses of the incompetency doctrine moved one commentator to advocate abandonment of the automatic bar doctrine in those jurisdictions which used the doctrine to invalidate any drug-induced competency as being "synthetic" and not genuine.<sup>63</sup> The same abuse avoidance argument could be equally applied to the rejection of the right to refuse antipsychotic drugs to gain *Dusky* competence for trial as promulgated by the *Mental Health Standards*.

The discussion so far of the possible policy rationales underlying the weakness of the right to refuse recognized by the *Mental Health Standards* in the case of incompetent detainees would be remiss if it did not point out that the ABA guidelines fail to address the great dangerousness of antipsychotic drugs in general<sup>64</sup> and do not define what constitutes an "unreasonable risk of serious, hazardous, or irreversible side effects."<sup>65</sup> Less intrusive means of attaining competence for trial, such as verbal psychotherapy or behavior modification techniques,<sup>66</sup> are possible alternatives that might support a defendant's decision to refuse the more intrusive and potentially dangerous drug therapy. Less intrusive methods of achieving competency to stand trial may not be as efficient or even as effective as antipsychotic medication; however, if there is some constitutional right to refuse antipsychotic medication, the state's admittedly strong interests in trying criminal defendants may be met with less than the most efficient means for achieving competency to stand trial.<sup>67</sup>

An issue inherently related to the right to refuse antipsychotic medication to induce competence is whether a defendant has a right to be

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<sup>59</sup> See Winick, *supra* note 5, at 792.

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

<sup>62</sup> *United States v. Lancaster*, 408 F.Supp. 225, 229 (D.D.C. 1976).

<sup>63</sup> See Winick, *supra* note 5, at 792.

<sup>64</sup> See generally *Antipsychotic Medication*, *supra* note 1.

<sup>65</sup> MENTAL HEALTH STANDARDS, *supra* note 3, at 7-4.10(d).

<sup>66</sup> Such techniques, while perhaps less effective than medication in treating the typical psychiatric disorders resulting in trial incapacity, are clearly less intrusive than drug therapy.

<sup>67</sup> The *Mental Health Standards* emphasis that the treatment be reasonable and ordinary implies reliance on the "professional judgment" standard of *Youngberg v. Romeo* 457 U.S. 307 (1982). The presumption of correctness associated with this standard may not require recognition of a right to the least intrusive form of treatment.

tried in an unmedicated state. The premise behind such a right is that the jury, which must decide whether a defendant was not responsible for his criminal offense due to mental illness, is inevitably influenced by how a defendant looks and acts in court during a trial.<sup>68</sup> The medication given during trial, which may be the sole means by which a psychotic defendant is able to understand the proceedings against him, may interfere with the jury's capacity to determine the degree of sanity of the defendant when the offense was committed. The *Mental Health Standards* approaches this issue in a no-nonsense manner. The Standards provide that if a defendant is only competent to stand trial with the aid of medication, he has the right to tell the jury that he is on medication and what effect the drugs may have on his demeanor; there is not right to actually appear before the jury in an unmedicated state.<sup>69</sup> Although the use of instructions to the jury to ignore what they have observed is subject to debate as to effectiveness,<sup>70</sup> the *Mental Health Standards* accepts their use to enable jurors to assess accurately a defendant's unmedicated mental state despite the altered appearance and demeanor in the courtroom. In the case of a defendant who has asserted mental irresponsibility, however, it is just as likely that a jury may view the medicated state of the defendant as the defendant's normal state and thereby discount the claim of irresponsibility.<sup>71</sup> In addition, a jury may legitimately question the credibility of a defendant whose demeanor, through the use of medication, has been rendered inappropriate to the occasion; a defendant whose emotions are dulled or whose responses are not appropriate to the emotional message

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<sup>68</sup> See, e.g., *In re Pray*, 133 Vt. 253, 257-58, 336 A.2d 174, 177 (1975). There is a risk that the defendant's condition at trial under medication would mislead the jury and prevent a fair trial.

<sup>69</sup> MENTAL HEALTH STANDARDS, *supra* note 3, at 7-4.14 states:

(a) A defendant should not be considered incompetent to stand trial because the defendant's present mental competence is dependent upon continuation of treatment or habilitation which includes medication, nor should a defendant be prohibited from standing trial or entering a plea solely because that defendant is being provided such services under professional supervision.

(b) If the defendant proceeds to trial with the aid of treatment or habilitation which may affect demeanor, either party should have the right to introduce evidence regarding the treatment or habilitation and its effects and the jury should be instructed accordingly.

This rule effectively abandons the automatic bar rule to "synthetic" competency, and is concerned only with the issue of triability and not the source of the present mental competence. This Note assumes that the issue of appearing before the jury in an unmedicated state was purposely omitted from the *Mental Health Standards*; it is also possible that its absence was an oversight or that the drafters had not discussed or arrived at a conclusion on this point.

<sup>70</sup> See, e.g., Allen, *When Jurors Are Ordered to Ignore Testimony, They Ignore the Order*, Wall St. J., Jan. 25, 1988, at B2, col. 3.

<sup>71</sup> Slovenko, *The Developing Law on Competency to Stand Trial*, 5 J. PSYCHIATRY & L. 165, 182 (1977).

conveyed by his testimony may create a false impression that he is lying.<sup>72</sup>

Thus, the *Mental Health Standards* recognizes neither a right for incompetent detainees to refuse antipsychotic drugs administered to induce *Dusky* competence to stand trial nor a due process right to be tried in a non-medicated state; this position finds some support in certain case law. In the 1978 case, *State v. Hayes*,<sup>73</sup> a defendant whose competence to stand trial was dependent upon treatment with antipsychotic drugs claimed a right to be tried in his unmedicated state. The New Hampshire Supreme Court ruled that the defendant lacked an absolute right to be tried free from the influence of drugs and would be compelled to be under medication for at least four weeks prior to the trial provided that the jury was instructed of these facts.<sup>74</sup> The *Hayes* court emphasized that antipsychotic drugs did not affect the process or content of the defendant's thoughts, but rather "allowed the cognitive part of the defendant's brain, which had been altered by the mental disease, to come back into play."<sup>75</sup> The court would not look beyond existing competency; the fact that it is synthetically induced is of no concern to the issue of triability.<sup>76</sup> It is interesting to note that, unlike the *Mental Health Standards*, the *Hayes* decision held that if the defendant so requests, he is entitled to be viewed by the jury after a period of non-medication equal to the length of time that he was drug-free at the time of the crime.<sup>77</sup> It is not clear from the *Hayes* opinion whether this limited right to appear in an unmedicated state is a due process entitlement to help the defendant assert an insanity

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<sup>72</sup> This criticism may be countered by comparison with a psychotic individual who commits a crime and recovers by the time of trial, without the benefit of medication. The jury will not be observing the individual in the same state as at the time of the crime. In spite of the defendant's altered trial demeanor, the jury is expected to attempt to conceptualize the accused as he was at the time of the crime in order to assess whether he was then insane. However, due process may require more (e.g., a tape of the defendant in his unmedicated state) where it is the state which is inducing or creating the altered demeanor. In *State v. Maryott*, 6 Wash. App. 96, 492 P.2d 239 (1971), a Washington court of appeals denied the state the ability to erase through medication "the major contours of the demeanor, appearance, and attitude of a defendant who is pleading his mental condition and then explain to the jury what they have, in effect, chosen for the jurors not to see." *Id.* at 99, 492 P.2d at 243.

<sup>73</sup> 118 N.H. 458, 389 A.2d 1379 (1978).

<sup>74</sup> *Id.* at 462, 389 A.2d at 1381.

<sup>75</sup> *Id.* This suggests that if antipsychotic drugs were shown to affect cognition, their use on a criminal defendant would be impermissible as a manifestation of the law's revulsion against state control over men's minds. See *Stanley v. Georgia*, 394 U.S. 557, 565 (1967) ("Our whole constitutional heritage rebels at the thought of giving government the power to control men's minds").

<sup>76</sup> See *State v. Hampton*, 253 La. 399, 218 So. 2d 311 (1969).

<sup>77</sup> 118 N.H. at 463, 389 A.2d at 1382. The time at which the jury is to view the defendant after he has stopped medication is a matter for the trial court to determine based on the evidence before it. Before committing his crime, Hayes had been taking Stelazine, Artane, and Valium but stopped the day before the crime. He was therefore held entitled to have the jury view him in a state as free from the effects of medication as he would have been after one unmedicated day. Expert testimony showed that he would have been under the influence of the medication at the time of the crime.

defense because simply informing the jury about his medicated status is an inadequate protection of the right to a fair trial.<sup>78</sup> The implication in *Hayes* may be that informing jurors of the fact of medication and giving them a description of the specific side effects of that medication on a particular defendant may be adequate only where the defendant's demeanor is not at issue in the case.<sup>79</sup>

In *State v. Jojola*,<sup>80</sup> the court of appeals of New Mexico was presented with a similar issue as the *Hayes* court. The defendant, who had a long history of mental illness, was found to be suffering from paranoid schizophrenia which caused him to feel persecuted by almost everyone with whom he came in contact.<sup>81</sup> The evidence showed that the defendant was competent to stand trial under *Dusky* as long as he was medicated with Thorazine, which was forcibly administered.<sup>82</sup> As in *Hayes*, the *Jojola* court endorsed the coercive use of medication to attain competence, but only with a drug like Thorazine, whose effect was described as "inhibiting or depressing the emotional part of the brain" but permitting the cognitive functions to make decisions and communicate with others.<sup>83</sup> While the defendant did not contest that the medication made him competent to stand trial, he nevertheless asserted a right to be tried free from the influence of Thorazine.<sup>84</sup> In pretrial hearings, *Jojola* stated an intention to show that children in his neighborhood made up stories about him and that the crime for which he was being prosecuted was one of these stories which had gotten out of hand. Therefore, his demeanor at trial would be relevant to the issue of whether the jury would believe that such stories could have been fabricated about him.<sup>85</sup> Since this theory was not pursued at trial, the *Jojola* court did not reach the issue of whether it would be an appropriate or necessary protection of due process to show the jury an unmedicated defendant. It was enough to afford the defense an opportunity to inform the jury as to the facts of Thorazine medication and its

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<sup>78</sup> Unfortunately, the *Hayes* opinion offers no analysis of its assumption that the defendant has no right to refuse antipsychotic medication.

<sup>79</sup> The MENTAL HEALTH STANDARDS, *supra* note 3, at 7-4.14(b) makes no provision for viewing a defendant in an unmedicated state, whether or not demeanor is an issue at trial and even if it is evident that the defendant was not medicated when the crime took place.

<sup>80</sup> 89 N.M. 489, 553 P.2d 1296 (1976).

<sup>81</sup> *Id.* at 491, 553 P.2d at 1298.

<sup>82</sup> *Id.*

<sup>83</sup> See *supra* note 75. As in *Hayes*, the *Jojola* ruling failed to discuss the reasons for its assumption that a mentally ill criminal defendant may be forcibly drugged to stand trial.

<sup>84</sup> Thorazine has the effect of sedating and producing a calmer demeanor. *Jojola* was being tried on two counts of aggravated sodomy.

<sup>85</sup> 89 N.M. at 493, 553 P.2d at 1300. One wonders why the defense counsel pursued this argument. Though an agitated appearance might lend credibility to the claim that children had made up stories about him, nonetheless a more refined demeanor would probably make it harder for a jury to believe that he had been the perpetrator of such a violent crime.



effects upon the defendant.<sup>86</sup> While *Jojola* may be cited to show that a mentally ill criminal defendant may be forced to attain drug induced competence and has no right to be tried in an unmedicated state, it is unclear from the case whether more is required than informing the jury about the defendant's "synthetic" competence where the defendant's demeanor is truly an issue in the case.<sup>87</sup>

In *State v. Law*,<sup>88</sup> the supreme court of South Carolina was confronted with a defendant who claimed that he could not be medicated against his will to achieve *Dusky* competence and that it was unlawful to try him while he was under the influence of antipsychotic medication. The *Law* court held that antipsychotic medication may be administered without the consent of a defendant under compelling circumstances, such as where the medication is necessary to render a defendant competent to stand trial.<sup>89</sup> *Law* also held that since the jury was informed through testimony

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<sup>86</sup> No effort was actually made by the defense to inform the jury that *Jojola* was on Thorazine treatment; this omission may have been interpreted by the New Mexico court of appeals as indicating a lack of seriousness on the part of the defense concerning the demeanor argument. *Id.*

<sup>87</sup> The *Jojola* court relied on both the fact that the defense had the opportunity to inform the jury about the Thorazine treatment, even though it chose not to, and the failure to pursue the "made up stories" theory at trial to conclude that due process had not been violated. The appropriateness of telling the jury that the defendant's demeanor has been medically altered is not without controversy. Compare *State v. Gwaltney*, 77 Wash. 2d 906, 468 P.2d 433 (1970) ("It is not a fact of which a judge or jury cannot be appropriately and effectively advised") with *Commonwealth v. Louraine*, 390 Mass. 28, 33, 453 N.E.2d 442 (1983) ("It cannot compensate for the positive value to the defendant's case of his own demeanor in an unmedicated condition.").

<sup>88</sup> 270 S.C. 664, 244 S.E.2d 302 (1978).

<sup>89</sup> *Id.* at 669, 244 S.E.2d at 307. The court cited Justice Brennan's concurring opinion in *Illinois v. Allen*, 397 U.S. 337 (1970) to show that the safeguards which the Constitution has been found to accord criminal defendants presupposes a compelling governmental interest in trying people who have been accused of violating valid laws. *Law* also relied upon *State v. Hampton*, 253 La. 399, 218 So. 2d 311 (1969) to provide legal precedent for a right to coerce medication. In *Hampton*, where modern American case law concerning the use of antipsychotic drugs to make a criminal defendant triable begins, as defendant who did not meet the *Dusky* standard persuaded the court to permit her to be tried while taking Thorazine. A state sanity commission had found that while under treatment Hampton had a present capacity to understand the proceedings and assist in her defense; the court held that the fact that this capacity was produced by antipsychotic medication was of "no legal consequence." *Id.* at 403, 218 So. 2d at 312. Hampton is viewed as establishing the proposition that the state has no interest in preventing the trial of a defendant who by taking medication could meet competency standards for trial; the court would "not look beyond existing competency and erase improvement produced by medical science." *Id.* The connection between the *Hampton* rejection of the automatic bar rule, which had excluded the acceptance of drug-induced competence as synthetic mind control, and the conclusion that the state may compel an unfit defendant to take antipsychotic drugs is not a logically necessary one. Read literally, *Hampton* only affirmed that the fitness to stand trial standard should be a current ability to function per *Dusky* and held that the fact that Hampton was only "synthetically sane" constituted no fraud upon the court. From the fact that the state has no interest in preventing treatment does not necessarily follow the conclusion that treatment may be compelled; however, *Law* seems to have reached precisely this conclusion.

about the defendant's mental history and present condition and knew that his claim demeanor at trial was the result of medication, the insanity defense was not undermined.<sup>90</sup>

In *United States v. Charters*,<sup>91</sup> the fourth circuit court concluded that a mentally ill pretrial detainee may be administered antipsychotic drugs against his will in order to maintain his competency to stand trial. Although the *Charters* court did not analyze why the government's position to forcibly medicate to obtain competency was stronger than the private interest to avoid bodily intrusion, it did characterize Charters' interest in freedom from bodily intrusion as only deserving protection against arbitrary and capricious government action.<sup>92</sup> The defendant in *Charters*, who had been arrested for threatening to kill President Reagan, maintained that his interest against being medicated involuntarily could be adequately protected only if a judicial hearing were required to determine whether he was competent enough to decide whether to accept the medication. The defendant continued that if he was found competent, his right to refuse should be honored. If found incompetent, the court could then make a substituted judicial judgment of the inmate's best interests.<sup>93</sup> The *Charters* court rejected the defendant's proposal as being far beyond what due process requires. The court cited *Youngberg v. Romeo*,<sup>94</sup> which held that decisions of treatment professionals should be treated by courts as presumptively valid and inherently nonarbitrary unless greatly divergent from industry standards.<sup>95</sup> Since the *Charters* decision dealt solely with the issue of forced medication at the pretrial stage, it never reached the issue of what safeguards adequately protect the defendant's due process rights during the trial, e.g., whether informing the jury that the defendant is medicated is enough.<sup>96</sup>

The *Charters* opinion is noteworthy because it assumes that a defendant who is mentally incompetent to stand trial cannot reasonably be judicially

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<sup>90</sup> In addition, it was emphasized to the jury that it was Law's mental state at the time of the murder and robbery that governed whether he was criminally responsible. 270 S.C. at 672, 244 S.E.2d at 306.

<sup>91</sup> 863 F.2d 302 (4th Cir. 1988).

<sup>92</sup> *Id.* at 308.

<sup>93</sup> *Id.* at 307. Interestingly, no suggestion was made to have decisions made by next of kin. The proposal would have cast district judges in the role of making medical and psychiatric decisions rather than reviewing the decisions of medical professionals. It is not surprising that the *Charters* court felt uncomfortable with such a regime and therefore rejected it. Of course, there is no reason to assume a medical diagnosis is more fallible than the comparable judicial diagnosis. See *Parham v. J.R.*, 442 U.S. 584 (1979) (base-line decisions to medicate should be made by medical professionals, subject to judicial review for arbitrariness).

<sup>94</sup> 457 U.S. 307 (1982).

<sup>95</sup> *Charters* was an involuntarily-committed psychiatric patient at the Federal Correctional Institution at Butner, North Carolina. As such, the decision to medicate him to maintain competence was based on the professional judgment of the government physicians at Butner.

<sup>96</sup> There is no reported case, to this author's knowledge, that deals with the issue of whether the jury has to be told that the defendant's current medicated state was induced against his will, rather than voluntarily.

declared competent to determine his own best interests in receiving or refusing medication. "While in theory there may be a difference between the two mental states, it must certainly be one of such subtlety and complexity as to tax perception by the most skilled medical or psychiatric professionals."<sup>97</sup> The court also held that the recognized potential of dangerous side effects from antipsychotic medication did not warrant the higher level of due process protection requested by the patient. This conclusion was based on the premise that if the side effects were consistently probable and severe, then antipsychotic medication should never be administered, even upon consent.<sup>98</sup> In effect, *Charters* stands for the premise that a mentally ill pretrial detainee is afforded no more than the right to ensure that his treatment is managed by a medical professional whose judgment is within the accepted standards of the medical profession. Under this standard, the question presented by a judicial challenge such as *Charters*' is not whether the treatment decision is demanded by the government's interest in trying those accused of violating its laws or even whether the decision to medicate was medically the most appropriate choice to maintain competence. All that is of consequence is whether the decision was made by a professional who has the knowledge to make such decisions through education, training, or experience,<sup>99</sup> in a nonarbitrary manner.<sup>100</sup>

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<sup>97</sup> *Charters*, 863 F.2d at 310. The dissent took issue with this contention and questioned the fairness of delegating the medication decision to a government medical official who may be inclined to agree with the federal prosecutor on the desirability of a trial proceeding and a resulting conviction. *Id.* at 315. The distinction between incompetence to stand trial or function in society and the ability to decide that one dislikes certain medication is accepted by many right to refuse cases that deal with involuntary civil commitment. See *infra* notes 128-132 and accompanying text. Even *Law, Jajola*, and *Hayes* failed to question the ability of a mentally ill defendant to intelligently refuse antipsychotic drugs; these cases only held that a defendant has no constitutional right to refuse or that the right must fall aside to the government interests in forcing competency to stand trial. See generally Note, *supra* note 7. One commentator observed that equating mental illness with legal incompetence is naive. See Fentinman, *Whose Right Is It Anyway?: Rethinking Competency to Stand Trial in Light of the Synthetically Sane Insanity Defendant*, 40 U. MIAMI L. REV. 1109 (1986).

<sup>98</sup> *Charters*, 863 F.2d at 311. Beginning with *Hampton*, "synthetic" competence has not only been tolerated in order to allow a trial to proceed, but has been encouraged where a defendant would otherwise be untriable. See *Bee v. Greaves*, 744 F.2d 1387 (10th Cir. 1984).

<sup>99</sup> *Romeo*, 457 U.S. at 323 n.30.

<sup>100</sup> The *amicus* brief for *Charters* by the American Psychological Association indicated that the substantial risk of deleterious side effects from antipsychotic medication made it more attractive to risk errors of incompetent judgment by a mental patient in declining medication than to risk the possible errors of professional misjudgment. This stance is reflective of the traditional psychodynamic model of mental illness which rejects the superiority of organic treatments over verbal psychotherapy. The *amicus* brief of the American Psychiatric Association supported the government's position by downplaying the incidence of substantial side effects to antipsychotic medication and describing how dangerous side effects such as tardive dyskinesia can be adequately managed medically. The APA *amicus* is apparently reflective of the belief of many in the psychiatric profession that heredity and biochemical imbalances are usually the main contributing factors in psychiatric disorders and need to be treated chemically, not verbally. *Charters*, 863 F.2d at 311 n.6.

*Hayes, Jojola, Law, and Charters* recognized the competency-restoring qualities of antipsychotic drugs and held that a mentally ill defendant had no right to refuse them where his competency to stand trial was at issue. Furthermore, *Jojola* and *Law* failed to recognize a due process right to be tried while in an unmedicated state. However, it does not necessarily follow that since the state's interests may be compelling enough to support forcible medication and deny the right to be tried without medication, that the state may also prevent a defendant from being observed by a jury at some time during trial in an unmedicated state. Such a simple due process device is especially warranted where the evidence indicates that a defendant was unaffected by medication at the time of the alleged crime. *Hayes*, where the right to refuse was rejected, nonetheless acknowledged that the defendant may request to be viewed without medication.<sup>101</sup> Thus, while the *Mental Health Standards'* position not to recognize a right to refuse antipsychotic drugs that would make a defendant competent to stand trial finds ample support in the case law and in the psychiatric profession,<sup>102</sup> its position that due process does not require that the jury see the defendant unmedicated at some point during trial (especially where insanity is claimed as the defense)<sup>103</sup> finds little support in the case law. In addition, it also does not follow from the compelling nature of the government's interest in upholding the dignity of the criminal justice system.

In assuming that a mentally incompetent defendant is currently required<sup>104</sup> to undergo treatment to achieve a mental state compatible with triability and is not entitled to present his unmedicated demeanor to the jury, the *Mental Health Standards* impliedly denies an incompetent detainee the right to waive being tried while competent. Theoretically, a defendant, at least after being restored to competence by medication, can assert a right to discontinue drugs and thereby waive in advance whatever due process right may exist in order not to be tried while incompetent.<sup>105</sup>

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<sup>101</sup> See also *In re Pray*, 133 Vt. 253, 336 A.2d 174 (1975).

<sup>102</sup> *Supra* note 100.

<sup>103</sup> The prejudicial effect of an unusually calm demeanor is of greatest concern when the defendant presents the defense of insanity. See *State v. Murphy*, 56 Wash. 2d 761, 355 P.2d 323 (1960) (new trial ordered for defendant given death penalty for murder; ingestion of tranquilizers prior to his testimony may have made defendant seem less remorseful and more calculating than he would otherwise have appeared). See also Bennett, *A Guided Tour Through Selected ABA Standards Relating to Incompetence to Stand Trial*, 53 GEO. WASH. L. REV. 375 (1985).

<sup>104</sup> See MENTAL HEALTH STANDARDS, *supra* note 3, at 7-4.10(d) and commentary at 223.

<sup>105</sup> See *supra* notes 22-26 and accompanying text. The defendant's right to be present at trial is not absolute. Like many procedural trial rights, it may be voluntarily waived. See *Snyder v. Massachusetts*, 291 U.S. 97, 106 (1984) (dictum); *Diaz v. United States*, 223 U.S. 442, 455-59 (1912). See also *Taylor v. United States*, 414 U.S. 17, 20 (1973) (upholding constitutionality of provision of the Federal Rules of Criminal Procedure allowing voluntary waiver of the defendant's right to be present). The defendant may also waive the right to be present by behaving in a manner that is "so disorderly, disruptive, and disrespectful of the court that his trial cannot be carried on with him in the courtroom." *Illinois v. Allen*, 397 U.S. 337, 343 (1970).

In *People v. Rogers*,<sup>106</sup> a California appellate court held that a defendant may waive the right to be present at trial by using medication with the intent of inducing incompetency.<sup>107</sup> Rogers, a diabetic, injected a large dose of insulin on the fourth day of his trial and willfully abstained from eating a sufficient breakfast.<sup>108</sup> Thus, the defendant had by his own actions impaired his mental state to the extent that he was not competent for trial; nevertheless, the state interest in having a competent defendant to insure the dignity of the criminal process was not invoked to invalidate the defendant's waiver of competency.<sup>109</sup>

In *State v. Hayes*,<sup>110</sup> the supreme court of New Hampshire, while recognizing the right of the state to coerce a defendant to take antipsychotic drugs to attain competency for trial, also held that if the defendant by his own voluntary choice, became incompetent to stand trial because of a refusal to take medication, he would be deemed to have waived the right to be tried while competent.<sup>111</sup> The *Hayes* court required that the court carefully examine the defendant on the record while competent, to establish:

that the defendant understands that if he is taken off the psychotropic medication he may become legally incompetent to stand trial; that he understands that he has a constitutional right not to be tried while legally incompetent; that the defendant voluntarily gives up this right by requesting that he be taken off the psychotropic medication; and that he understands that the trial will continue whatever his condition may be.<sup>112</sup>

The Massachusetts supreme court, in the 1983 case of *Commonwealth v. Louraine*,<sup>113</sup> held that a mentally ill defendant in a homicide case had a right to be tried in an unmedicated state. The court considered the drug's effect on the defendant's demeanor where sanity at the time of the offense is an issue and held that if the defendant is willing to waive being tried while competent in order to present his real demeanor to the jury, he has the right to do so.<sup>114</sup>

<sup>106</sup> 150 Cal. App. 2d 403, 309 P.2d 949 (1957).

<sup>107</sup> *Id.* at 415, 309 P.2d at 957.

<sup>108</sup> *Id.* at 409, 413, 309 P.2d at 953, 955. As a result, he experienced insulin shock and could not assist in his defense.

<sup>109</sup> The court's concern in *Rogers* was whether the defendant's right to be present at trial was violated, not the state's interest in having a competent defendant. If the waiver of presence is accepted, the trial continues without the accused.

<sup>110</sup> 118 N.H. 458, 389 A.2d 1379 (1978).

<sup>111</sup> *Id.* at 462, 389 A.2d at 1382. Presumably, Hayes wanted to present his true demeanor to the jury.

<sup>112</sup> *Id.*

<sup>113</sup> 390 Mass. 28, 453 N.E.2d 437 (1983).

<sup>114</sup> *Id.* at 38 n.13, 453 N.E.2d at 444 n.13. See also *Chambers v. Mississippi*, 410 U.S. 284, 302-03 (1973); *Washington v. Texas*, 388 U.S. 14, 19 (1967).

<sup>115</sup> See Note, *supra* note 48, at 457-58. The interest in appearing free of the medication's effects may also benefit the prosecution in that it permits the accused to show off his "mad dog" side. See Bennett, *supra* note 103, at 410 n.190.

The rejection by the *Mental Health Standards* of the right of a mentally ill criminal defendant to be tried while incompetent, through waiver of his constitutional right to be present, may be explained as an assertion of the state's interest in the accuracy, dignity, and apparent fairness of the criminal process.<sup>115</sup> However, not allowing the appearance of the natural demeanor of a defendant at some point during the trial in the interest of judicial fairness is indeed difficult to justify. If in fact the *Mental Health Standards* position that the state may forcibly medicate to attain trial competency is meant to apply to a pretrial detainee, an inconsistency may exist between the denial of the right to refuse prior to trial with the recognition of such a right by a convicted prisoner.<sup>116</sup>

#### IV. THE ARGUMENTS SUPPORTING A RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION EVEN WHERE THE MEDICATION RESULTS IN COMPETENCY TO STAND TRIAL

An early reported case that held that a defendant may not be forced against his will to take drugs in order to attain competence to stand trial is the 1971 case of *State v. Maryott*,<sup>117</sup> in which the Washington court of appeals was asked to decide whether the state had a right, over the defense counsel's objection, to administer drugs which affect the defendant's mental and/or physical abilities at the time of trial; and particularly, whether the state may do so where the defendant's mental responsibility to commit the crime is at issue.<sup>118</sup> The *Maryott* court held that the state was prohibited from forcing the drugs upon the defendant in either situation because no state interest could justify such intrusive and total control over an accused.<sup>119</sup> While it may be inferred from the court's opinion that the medication was not administered to enhance mental competence to stand trial, but to control possible courtroom misbehavior,<sup>120</sup> thus distinguishing the opinion from the *Mental Health Standards'* right to forcibly drug to attain *Dusky* competence, the due process argument used in the *Maryott* opinion may have cogent force even where the goal is to produce a triable defendant. In holding that *Maryott's* due process rights had been violated, the court looked to several cases which held that defendants could not be chained or shackled in court since doing so would subject them to physical pain. "To apply the historical concerns

<sup>116</sup> MENTAL HEALTH STANDARDS, *supra* note 3, at 7-10.9. See also *Bell v. Wolfish*, 441 U.S. 520, 545 (1979) (pretrial detainees "retain at least those constitutional rights that we have held are enjoyed by convicted prisoners").

<sup>117</sup> 6 Wash. App. 96, 492 P.2d 239 (1971). See generally *Silten & Tullis, Mental Competency in Criminal Proceedings*, 28 HASTINGS L.J. 1053, 1054 (1977).

<sup>118</sup> *Maryott*, 6 Wash. App. at 97, 492 P.2d at 240.

<sup>119</sup> *Id.*

<sup>120</sup> It is not clear from the case why *Maryott* was administered antipsychotic medication, *Id.* at 105, 492 P.2d at 243.

about shackling to cases involving drugs, which may have the same or more deleterious effects, is only to give a more current application to a basic concern."<sup>121</sup>

In addition to expressing a concern that Maryott's due process rights may have been violated by the physical effects of the drugs on him, the court held that a separate due process issue was also implicated; that through the administration of antipsychotic drugs, the state was in effect choosing for the jurors exactly which demeanor of the defendant would be available for viewing.<sup>122</sup> If, for example, a defendant were to appear at his trial in prison clothing, the jury may or may not tend to be prejudiced against him. Where such prejudice is possible, however, the Supreme Court has held that the state cannot compel a defendant to wear such attire.<sup>123</sup> A defendant in shackles or prison stripes presents a different persona to the jury than a defendant in a business suit. The same may be said of treatment with antipsychotic drugs. Although the drugged defendant's altered demeanor may have no prejudicial effect on the jury, the point of *Maryott's* analogy to the chaining and shackling cases, along with the Supreme Court's decision regarding prison garb, may be that the state may not coerce a defendant into a position of even potential prejudice.<sup>124</sup>

Some of the right to refuse cases in the civil commitment and post criminal conviction areas shed light on the assertable interests that an accused may have to attempt to halt the forcible administration of antipsychotic medication to attain competence to stand trial. In *Davis v. Hubbard*,<sup>125</sup> which involved a challenge of the conditions at a state mental institution, the court probed the historical basis of the right to refuse unwanted medical treatments and pointed out that the law of torts has long recognized a person's interest in making decisions about his body.<sup>126</sup> The *Davis* court concluded that the forced use of antipsychotic drugs represents a significant invasion of an individual's fundamental right to privacy.<sup>127</sup> The court also held that there is no necessary relationship

<sup>121</sup> *Id.* at 100, 492 P.2d at 242. For discussion of the painful side effects of antipsychotic medication see generally Winick, *Incompetency to Stand Trial: An Assessment of Costs and Benefits And A Proposal For Reform*, 39 RUTGERS L. REV. 243 (1987) [hereinafter *Incompetency to Stand Trial*]; Winick, *Legal Limitations on Correctional Therapy and Research*, 65 MINN. L. REV. 331, 365 (1981) [hereinafter *Legal Limitations*].

<sup>122</sup> *Maryott*, 6 Wash. App. at 105, 492 P.2d at 243.

<sup>123</sup> *Estelle v. Williams*, 425 U.S. 501, 507-08 (1976); cf. *Illinois v. Allen*, 397 U.S. 337, 344 (1970) (court removal preferred to binding or gagging disruptive defendant due to impact "on the jury's feelings about the defendant").

<sup>124</sup> *Maryott* never considered the adequacy of telling the jury about the source of the defendant's altered demeanor as a means of dealing with the due process considerations.

<sup>125</sup> 506 F. Supp. 915 (N.D. Ohio 1980).

<sup>126</sup> *Id.* at 931-32.

<sup>127</sup> *Id.* at 929-30; accord *Rennie v. Klein*, 653 F.2d 836, 843-44, vacated and remanded for further consideration, 458 U.S. 1119 (1982), on remand, 720 F.2d 266 (3d Cir. 1983) (*en banc*); *Mills v. Rogers*, 457 U.S. 291 (1982), on remand, 738 F.2d 1 (1st Cir. 1989); *Rogers v. Okin*, 684 F.2d 650, 653-54 (1st Cir. 1980), vacated and remanded on other grounds *sub nom.*

between mental illness and the type of incompetency which would render a patient unable to provide informed consent to medical treatment.<sup>128</sup> Moreover, the *Davis* decision discussed how the efficacy of antipsychotic medication depends on the existence of a trusting relationship between psychiatrist and patient<sup>129</sup> and how such a relationship may be impliedly absent where a patient/defendant looks to the courts for protection against unconsented medication. It has been the impression of the trial courts in several of the right to refuse cases that drug refusals were, for most patients, motivated by a desire to avoid the drug's unpleasant side effects<sup>130</sup> or based on a personal appraisal that the drugs were not helping the patient's condition.<sup>131</sup> The *Davis* court found that eighty-five percent of inpatients were capable of making rational decisions on whether to consent to the use of antipsychotic medication.<sup>132</sup>

The conclusion that an individual has a constitutionally protected interest in making his own decisions whether to accept or reject the administration of potentially dangerous drugs is supported by the Supreme Court's decision in *Whalen v. Roe*.<sup>133</sup> *Whalen* involved an action by physicians and patients challenging the constitutionality of a statute requiring that New York State be provided with a copy of all prescriptions for certain drugs.<sup>134</sup> Justice Stevens, writing for a unanimous court, specifically recognized a privacy interest "in independence in making certain kinds of important decisions."<sup>135</sup> The *Davis* court implicitly held that the decision whether to accept treatment with antipsychotic drugs is of sufficient importance to fall within the category of privacy interests recognized by *Whalen* as protected by the Constitution.<sup>136</sup> Another suggested basis for the right to refuse antipsychotic drug treatment is the freedom from bodily restraint interest recognized by the Supreme Court in *Youngberg v. Romeo*.<sup>137</sup> In *Romeo*, a severely retarded man who had been involuntarily committed to a mental institution was subjected to physical

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<sup>128</sup> *Davis*, 506 F. Supp. at 935. This distinction gives weight to the principle that one may be incompetent to stand trial, but competent to make treatment decisions. Professor Brooks has pointed out that medication refusal is often an "amalgam of rational and irrational reasons, mental illness and non-mental illness induced." See Brooks, *supra* note 1, at 209.

<sup>129</sup> *Davis*, 506 F. Supp. at 936.

<sup>130</sup> See, e.g., *Rennie v. Klein*, 462 F. Supp. 1131, 1140 (1978).

<sup>131</sup> See, e.g., *Rennie v. Klein*, 476 F. Supp. 1294, 1305 (1981).

<sup>132</sup> *Davis*, 506 F. Supp. at 927. Of the 15% incapable of making such decisions, few have been found to be incapable by a neutral party. Rather, an often biased treating staff makes this determination. *Id.* at n.8.

<sup>133</sup> 429 U.S. 589 (1977).

<sup>134</sup> *Id.*

<sup>135</sup> *Id.* at 599-600 (non-disclosure of personal matters; independence in decision-making).

<sup>136</sup> As with all fundamental interests, this decision may be validly waived only if the waiver is voluntary, knowing, intelligent, and done with "sufficient awareness of the relevant circumstances and likely consequences." *Brady v. United States*, 397 U.S. 742, 748 (1970).

<sup>137</sup> 457 U.S. 307 (1982).



soft restraints. The Court stated that the liberty interest from bodily restraint even survives criminal conviction and incarceration.<sup>138</sup> If incarcerated individuals retain a liberty interest in freedom from bodily restraints of the kind in *Romeo*, then they certainly have a liberty interest in freedom from physical and mental restraints of the kind potentially imposed by antipsychotic drugs.<sup>139</sup> By extension, if imprisoned convicts enjoy a right to refuse antipsychotic treatment, an accused awaiting trial who has a presumption of legal innocence should certainly have at least the same protection against liberty deprivation.

Although *Romeo* may provide a basis for the right to refuse, this Note has previously indicated that the effect of the protection afforded in the Court's opinion, professional medical judgment which is presumptively valid, has reduced the right from a judicial hearing to a right to a second opinion.<sup>140</sup> However, the appropriateness of using *Romeo*'s professional judgment standard in the context of potentially dangerous medication forced upon a patient or accused awaiting trial is not altogether clear.<sup>141</sup> *Romeo* is distinguishable both because it involved temporary physical restraints rather than mental restraints with potentially long term effects<sup>142</sup> and because *Romeo* had been certified as severely retarded and unable to care for himself, as opposed to involuntarily committed individuals and to the accused awaiting trial, who are presumed capable of refusing drugs.<sup>143</sup> *Romeo*'s impact may be reflected by the absence of any provision in the *Mental Health Standards* for a determination of whether an accused awaiting trial is incapable of expressing an understanding of the advantages and disadvantages of accepting antipsychotic drugs and the alternatives to accepting the particular treatment offered, after the advantages, disadvantages, and alternatives have been explained. The *Romeo* decision is also significant in that the Court declined to apply a "less intrusive means" analysis to a decision regarding treatment of an involuntarily committed mental patient. Similarly, the *Mental Health Standards* lacks a requirement of such analysis where triability is the goal sought.<sup>144</sup>

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<sup>138</sup> *Id.* at 316.

<sup>139</sup> See *Project Release v. Prevost*, 551 F. Supp. 1298, 1309 (E.D.N.Y. 1982), *aff'd*, 722 F.2d 960 (2d Cir. 1983).

<sup>140</sup> See *supra* note 20 and accompanying text.

<sup>141</sup> The Court obviously held this standard was relevant to the patient context since it remanded *Rennie*, 720 F.2d at 266 (3d Cir. 1983) to the United States court of appeals for the third circuit for further consideration in light of *Romeo*.

<sup>142</sup> Antipsychotic drugs are an arguably greater and possibly irreversible infringement on the liberty interest at stake. See *Rennie*, 720 F.2d at 274-77.

<sup>143</sup> Institutional attitudes toward committed patients have changed; in the past, most state psychiatric patients were generally presumed legally incompetent for all purposes. This presumption of incompetence has for the most part been reversed. See, e.g., *State ex. rel. Jones v. Gerhardstein*, 141 Wis. 2d 710, 740, 416 N.W.2d 883, 895 (1987).

<sup>144</sup> There is a safeguard against the undefined unreasonable risk of serious, hazardous or irreversible side effects. MENTAL HEALTH STANDARDS, *supra* note 3, at 7-4.10(d).

While the Supreme Court opinion in *Romeo* has been interpreted as effectively closing the door to a meaningful federal constitutional right to refuse antipsychotic medications,<sup>145</sup> several leading state courts continue to insist upon a right to refuse that has some substance. In *Rogers v. Commissioner of Dept. of Mental Health*,<sup>146</sup> the supreme court of Massachusetts held that under state common law, since involuntary commitment is not a determination that the individual is incompetent to make treatment decisions, such a determination must be made by the judge before a committed individual can be forcibly administered antipsychotic drugs in a non-emergency situation. *Rogers* held that if an involuntarily committed individual is judicially determined to be incompetent to exercise informed consent for the administration of antipsychotic drugs, a guardian should be appointed to monitor treatment.<sup>147</sup> In *Opinion of the Justices*,<sup>148</sup> the New Hampshire supreme court interpreted the state constitution as requiring a prior finding of incompetency with "procedural protection to the patient" before forcibly giving antipsychotic medication to involuntarily committed patients.<sup>149</sup>

The Colorado supreme court in the 1985 case of *People v. Medina*,<sup>150</sup> held that under state common law, antipsychotic medication may be administered to non-consenting involuntarily committed individuals in non-emergency situations only after a judicial determination that there is clear and convincing evidence that the individual is incapable of making an informed treatment decision. The court also required a finding that the treatment with antipsychotic drugs is necessary to prevent a significant and possibly long-term deterioration in the individual's mental condition and in addition, a less intrusive treatment alternative is not available.<sup>151</sup> In the 1986 case of *Rivers v. Katz*,<sup>152</sup> the New York court of Appeals recognized a state constitution and common law right of involuntarily committed individuals to exercise informed consent for the administration of antipsychotic drugs. The court rejected the state's argument that committed individuals were presumptively incompetent

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<sup>145</sup> See *Antipsychotic Medication*, *supra* note 20, at 367.

<sup>146</sup> 390 Mass. 489, 458 N.E.2d 308 (1983).

<sup>147</sup> *Id.* at 497, 458 N.E.2d at 318. *Rogers* was a reply to questions that had been certified to the Supreme Judicial Court by the United States court of appeals for the first circuit and was the actual resolution of the case considered by the Supreme Court in *Mill v. Rogers*, 457 U.S. 291 (1982).

<sup>148</sup> 123 N.H. 554, 465 A.2d 484 (1983).

<sup>149</sup> *Id.* at 562, 465 A.2d at 490.

<sup>150</sup> 705 P.2d 961 (Colo. 1985).

<sup>151</sup> 705 P.2d 974. The court also looked at whether the need for treatment is sufficiently compelling to override any legitimate refusal of such, but did not indicate what state interests could be compelling, other than patient welfare. The emphasis in the state right to refuse cases on patient welfare starkly contrasts with the emphasis on the state's interest and the duties of a mentally ill defendant in the competency to stand trial cases and the MENTAL HEALTH STANDARDS, *supra* note 3, at 7-4.10. See Perlin, *supra* note 19, at 28 n.17.

<sup>152</sup> 67 N.Y. 2d 485, 495 N.E.2d 337 (1986).

to exercise informed consent and held that the right to consent could only be overridden after a judicial hearing where a court found that the individual lacked the capacity to give informed consent and that the benefits of the antipsychotic drugs to the individual outweighed their possible adverse effects.<sup>153</sup> Part of the significance of the foregoing cases, dealing with the right of involuntarily committed patients to refuse and the defendant who is incompetent to stand trial, is the following: a mental patient may disagree with psychiatric judgment that the benefit of medication outweighs the cost and nonetheless remain competent to make such a decision. Consequently, the decision by an accused awaiting trial to refuse competency enhancing medication may be entitled to the presumption of being a capably made decision.

In the 1987 case, *State ex. rel. Jones v. Gerhardstein*,<sup>154</sup> the supreme court of Wisconsin held that a Wisconsin law which granted the right to refuse treatment to persons held in pre-commitment detention, but not to the class of persons actually involuntarily committed, violated equal protection afforded by the United States and Wisconsin Constitutions.<sup>155</sup> After reaffirming the consensus among the civil right-to-refuse decisions that an involuntary commitment is not equivalent to a finding of incompetence with respect to involuntary treatment decisions,<sup>156</sup> the *Gerhardstein* court held that a determination of competency to refuse must be made in an adversarial setting in order to avoid having individuals routinely declared incompetent for the sake of "mere convenience, control or expense."<sup>157</sup> *Gerhardstein* may be interpreted as suggesting a possible equal protection challenge to a scheme which ignores the right of a mentally ill accused awaiting trial to exercise informed consent, while granting the right to refuse to a convicted prisoner who is mentally ill.<sup>158</sup>

In 1988, the supreme court of Minnesota, in *Jarvis v. Levine*,<sup>159</sup> dealt directly with the relevance of *Romeo's* professional judgment standard to the area of forcible medication of the mentally ill. *Jarvis* explicitly held that the Supreme Court's decision in *Romeo* offered little guidance since it dealt with a patient obviously incapable of giving informed consent<sup>160</sup> and with the issue of freedom from bodily restraint, not the issue of forced drug treatment and its potentially devastating effects.<sup>161</sup> The *Jarvis* opinion found the intrusive nature of antipsychotic medication to be acknowl-

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<sup>153</sup> *Id.* at 493-94, 495 N.E.2d at 341-42.

<sup>154</sup> 141 Wis. 2d 710, 416 N.W.2d 883 (1987).

<sup>155</sup> *Id.* at 737, 416 N.W.2d at 892 (court found it unnecessary to determine issue based on invasion of bodily autonomy).

<sup>156</sup> *Id.* at 742, 416 N.W.2d at 896.

<sup>157</sup> *Id.* at 744, 416 N.W.2d at 898.

<sup>158</sup> Compare MENTAL HEALTH STANDARDS, *supra* note 3, at 7-4.10 (no right to refuse treatment designed to affect competence to stand trial) with MENTAL HEALTH STANDARDS, *supra* note 3, at 7-10.9 (right of prisoner to refuse treatment).

<sup>159</sup> 418 N.W.2d 189 (1980).

<sup>160</sup> *Romeo* had the mental capacity of an 18 month-old baby and was obviously unable to participate in any treatment decisions.

<sup>161</sup> *Jarvis*, 418 N.W.2d at 197.

edged by even the most vocal supporters of its use as part of a therapeutic plan.<sup>162</sup> The court found that the use of antipsychotic medication had to be subject to the same procedural guidelines as electroconvulsive therapy (ECT) and psychosurgery.<sup>163</sup> The procedure was to include a judicial consideration of the patient's ability to competently determine for himself whether the treatment is desirable.<sup>164</sup> While acknowledging that it would be unreasonable for the courts to become involved in every treatment decision for the mentally ill, *Jarvis* held, in spite of *Romeo*, that the judicial system cannot abdicate all responsibility for protecting a mentally ill person's fundamental rights just because some degree of medical judgment is implicated.<sup>165</sup> Special procedures needed to be followed for psychosurgery, ECT, and antipsychotic drug administration. To deny mentally ill individuals the right to refuse such intrusive treatments would "deprive them of basic human dignity by denying their personal autonomy."<sup>166</sup> The analogy between ECT and antipsychotic medication may be highly significant; the Commentary to the *Mental Health Standards* admits that ECT may be so intrusive that it may not be forcibly used to gain competency for trial for a mentally ill criminal defendant.<sup>167</sup>

In the 1988 case of *Harper v. State*,<sup>168</sup> which is currently being reviewed by the United States Supreme Court, the supreme court of Washington also found that antipsychotic drug treatment is no less intrusive than ECT and concluded that a judicial hearing is required before the state may administer antipsychotic drugs to a prisoner against his will.<sup>169</sup> The *Harper* holding that the constitutional liberty interest in refusing ECT and antipsychotic drug treatment survives criminal conviction and incarceration as well as civil involuntary commitment may by extension accord the same right to an accused awaiting trial. *Harper* provides that a judicial hearing determines whether there exists a compelling state interest in administering antipsychotic drugs against a prisoner's will and whether the treatment is necessary and effective.<sup>170</sup> Why isn't there

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<sup>162</sup> See Gutheil & Appelbaum, "Mind Control," "Synthetic Sanity," "Artificial Competence," and *Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 HOFSTRA L. REV. 77, 99-117 (1983). *Jarvis* acknowledged that the Supreme Court has not yet directly dealt with the issue of forcible medication of the mentally ill. *Jarvis*, 418 N.W.2d at 194.

<sup>163</sup> *Jarvis*, 418 N.W.2d at 194. See *Price v. Sheppard*, 307 Minn. 250, 239 N.W.2d 905 (1976) (decision to forcibly treat patients with ECT and psychosurgery required pretreatment judicial review due to severity of potential side effects). See also *supra* note 93 and accompanying text.

<sup>164</sup> *Jarvis*, 418 N.W.2d at 194.

<sup>165</sup> *Id.* at 196.

<sup>166</sup> *Id.* at 197.

<sup>167</sup> But only if the defense objects! MENTAL HEALTH STANDARDS, *supra* note 3, at 7-4.10 and commentary n.2.

<sup>168</sup> 110 Wash. 2d 873, 759 P.2d 358 (1988). See *supra* note 13.

<sup>169</sup> *Id.* at 881-82, 759 P.2d at 363. See also *Guardianship of Roe*, 383 Mass. 415, 421 N.E.2d 40 (1981) (antipsychotic medication should be treated in the same manner as ECT or psychosurgery).

<sup>170</sup> *Harper*, 110 Wash. 2d at 884, 759 P.2d at 364. For a recent article describing the state *Harper* decision and the issues argued in the case before the United States Supreme Court, see Jost, *The Right To Say No*, A.B.A.J. 72 (Feb. 1990). See *supra* note 13.

a similar hearing to determine the same information prior to forcibly administering antipsychotic drugs to attain the competence to become a convicted prisoner?

Although the right-to-refuse cases differ with respect to how the situation of a patient/prisoner who is found incompetent to make a treatment decision should be handled,<sup>171</sup> the cases agree that there is a presumption of competency to refuse and that the right to refuse, whatever its source, can only be overcome by a compelling state interest.<sup>172</sup> The tenth circuit court held, in the 1984 case of *Bee v. Greaves*,<sup>173</sup> that the state of Utah could not justify forcing a prisoner to take antipsychotic drugs on the basis of a need to keep a pretrial detainee competent for trial where it had already been determined that he was not mentally ill and was competent to stand trial.<sup>174</sup> The *Bee* court doubted whether the state interest in bringing to trial those accused of a crime could ever be sufficiently compelling to outweigh a defendant's interest in not being forcibly medicated with antipsychotic drugs, even if he is otherwise incompetent to stand trial.<sup>175</sup> In contrast with the emphasis placed upon the functioning of the trial system by the *Mental Health Standards* as warranting forced medication, the *Bee* opinion acknowledged the potentially dangerous side effects of antipsychotic drugs in concluding that the needs of the individual and not the requirements of the prosecutor should control when antipsychotic drugs are considered.<sup>176</sup> The *Bee* court's conclusion that antipsychotic drugs could not be employed to attain trial competency was based upon analogy to the statutory recognition by Utah of the right of a mentally ill person not to be subjected to involuntary mental treatment absent a hearing at which the court finds "the patient lacks the ability to engage in a rational decision-making process regarding the acceptance of mental treatment as demonstrated by evidence of inability to weigh the possible costs and benefits of treatment."<sup>177</sup> *Bee* may therefore stand for the premise that the right to refuse as a manifestation of personal dignity and protection against state intrusiveness, which has found ample expression in the civil commitment cases, is equally appropriate to the

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<sup>171</sup> Some decisions, such as *Harper*, provide for judicial substituted judgment. Others, like *Jarvis*, allow forcible medication once the issue of competency to refuse has been judicially reviewed.

<sup>172</sup> Whether competency to stand trial is a compelling enough state interest to outweigh a fundamental liberty right remains to be litigated.

<sup>173</sup> 744 F.2d 1387 (1984).

<sup>174</sup> *Id.* at 1395. Although the court found him *Dusky* competent, it is unclear whether this determination was made while *Bee* was on or off Thorazine. See also *Washington v. Harper*, 110 S. Ct. 1028, 1051 n.19 (1990) (Stevens, J., dissenting).

<sup>175</sup> *Bee*, 744 F. 2d at 1395.

<sup>176</sup> *Id.*

<sup>177</sup> *Id.* (quoting UTAH CODE ANN. §64-7-36(10)(c) (Supp. 1983)). No such determination had been made with regard to *Bee*.

criminal context where competency to stand trial is the articulated state interest.<sup>178</sup>

#### V. ADDITIONAL CONCERNS WITH FORCIBLY MEDICATING A MENTALLY ILL DEFENDANT TO ATTAIN COMPETENCY TO STAND TRIAL

The *Mental Health Standards* provides no right to refuse "ordinary and reasonable treatment" to restore trial competence, but does recognize a liberty interest in refusing hazardous medication.<sup>179</sup> That the *Mental Health Standards* includes antipsychotic medication within the description of ordinary and reasonable<sup>180</sup> is difficult to explain given that the primary and side effects of many of these drugs are both physically and mentally intrusive, occur rapidly, and are not capable of being resisted.<sup>181</sup> Research conducted on several of the antipsychotic drugs confirms that patients whose subjective response to antipsychotic medication is negative suffer even more severe side effects than those who do not refuse.<sup>182</sup> Much of the impetus that propelled the development of at least a qualified right to refuse in the patient/prisoner context was the evidence that antipsychotic drugs were being abused in institutions to control the patients.<sup>183</sup> There seems to be ample cause for an equivalent amount of concern for abuse in the trial setting where the states interest may be so compelling as to invoke treatment that in another context might reasonably be labelled abusive. Involving an accused in deciding what form of treatment to attain competency would be most acceptable is not only responsive to a mentally ill defendant's needs but also may enhance his willingness to cooperate in the trial process.<sup>184</sup>

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<sup>178</sup> It is ironic that this strong recognition of a parallel right to refuse should come in a federal court, since the federal right to refuse even in the civil setting is generally weaker than the state right to refuse. See Callahan & Longmire, *Psychiatric Patients' Right to Refuse Psychotropic Medication: A National Survey*, 7 MENTAL DISABILITY L. REP. 494, 495 (1983) (forty-five states recognized a qualified right to refuse medication).

<sup>179</sup> MENTAL HEALTH STANDARDS, *supra* note 3, at 7-4.10(d).

<sup>180</sup> *Id.* and commentary n.1.

<sup>181</sup> See *Legal Limitations*, *supra* note 121, at 366-67. See also Gelman, *Mental Health Drugs, Professionalism, and the Constitution*, 72 GEO. L. J. 1725, 1751 (1984) (antipsychotic drugs "possess a remarkable potential for undermining individual will and self-direction, thereby producing a psychological state of unusual receptiveness to the directions of custodians.")

<sup>182</sup> Van Putten & May, *Subjective Response as a Predictor of Outcome in Pharmacotherapy: The Consumer Has a Point*, 35 ARCH. GEN. PSYCHIATRY 477 (1978). See also *Washington v. Harper*, 110 S. Ct. 1028, 1049 n.11, 1050 n.15, 1051 n.18 (1990) (Stevens, J., dissenting).

<sup>183</sup> When John Rennie complained about Prolixin, the doctor doubled his dose. See *Antipsychotic Medication*, *supra* note 1, at 189. The *Rennie* Court noted that a nurse who had recorded Rennie's adverse side effects was later criticized and intimidated for doing so by her superiors. *Id.* at 188.

<sup>184</sup> See *Antipsychotic Medication*, *supra* note 20, at 375 (involvement has been found to enhance patient dignity in institutional setting while not increasing illness).

The coercive use of antipsychotic drugs to enable a criminal defendant to meet the *Dusky* standard may raise additional problems. Drugs that affect the emotions may inhibit the defendant's ability to function properly as defendant. Although the desired effects of antipsychotic medication may gain for the defendant a capacity to understand the proceedings and assist his counsel, other effects of the drugs such as diminished anxiety, unnatural apathy and an increased level of trust for adversaries may diminish his motivation to help his lawyer's defense. Thus, although the patient may be technically competent per *Dusky*, he may nonetheless be denied what should arguably be the state's proper interest, a *fair* trial.

Additionally, the high possibility of unwarranted prejudice in the eyes of the trier of fact due to the altered personality and behavior of a defendant on antipsychotic drugs may not be adequately addressed by way of explanation.<sup>185</sup> Furthermore, just as a witness might be tempted to lie about an absent defendant, he might also be tempted to do so about an unusually placid or distant one.

It is evident from the case law that criminal cases have often emphasized the state's intended effects of antipsychotics and have given little or diminished attention to adverse side effects. By contrast, the civil courts which have addressed the right of psychiatric patients to refuse antipsychotic medication have generally done so by reference to the drugs' deleterious effects.<sup>186</sup> While it is obvious that the state's asserted interests differ in the criminal and civil commitment areas,<sup>187</sup> it is less clear why the legal analysis and judicial concern about the deleterious side effects of antipsychotic drugs that the civil decisions bring to the right to refuse should not find equivalent relevance in the criminal area. Even the fear that a mentally ill criminal defendant may attempt to avoid trial by feigning or inducing incompetence may be adequately handled with less intrusive methods than forcible antipsychotic medication. Indeed it might be fairer, given the intrusive nature of the antipsychotics, to waive the competency requirement rather than compelling it against a defendant's will.<sup>188</sup>

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<sup>185</sup> It may be quite difficult for a jury to look past the emotionless and rational defendant in court and see the serious psychosis from which he suffers. Furthermore, it may be unreasonable to expect a jury to acknowledge the seriousness of a mental disease that can be "cured" by a brief course of treatment with drugs that are considered not to impair mental processes. A psychiatrist who testified on behalf of a defendant recognized this dilemma. When asked whether the defendant was better able to assist his attorney while taking antipsychotic drugs, the doctor replied, "This I cannot answer directly because maybe his attorney's defense would be better when he is at his worst." *Quoted in* COMMITTEE ON PSYCHIATRY AND LAW, GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, MISUSE OF PSYCHIATRY IN THE CRIMINAL COURTS: COMPETENCY TO STAND TRIAL 876 (1975).

<sup>186</sup> See Gutheil & Applebaum, *supra* note 162, at 96-98.

<sup>187</sup> See *Antipsychotic Medication*, *supra* note 1, at 201-13.

<sup>188</sup> See *Incompetency to Stand Trial*, *supra* note 121, at 261.

VI. ALTERNATIVES TO FORCIBLE MEDICATION TO ATTAIN COMPETENCY  
TO STAND TRIAL

Constitutional law has long recognized the "least restrictive alternative" argument to invalidate excessive state regulation of fundamental constitutional rights.<sup>189</sup> In view of the severe side effects of antipsychotic drugs, forcible medication cannot be viewed as a reasonable response to the need to achieve competence for trial if there exists "less drastic means for achieving the same basic purpose."<sup>190</sup> In the civil cases, the least restrictive alternative to forcible antipsychotics has included seclusion, a less intrusive alternative medication like tranquilizers or sedatives, an alternative therapy or even a temporary discontinuation of medication.<sup>191</sup> Professor Brooks has written:

The least restrictive alternative doctrine, if properly applied, encourages the striking of a balance between efficacy and intrusiveness. The emphasis is not exclusively on avoiding an intrusion. Rather, the concept stresses the avoidance of unnecessary or gratuitous intrusions which may occur because of rigidity, inattentiveness or lack of sensitivity. The efficacy issue is important. An efficacious treatment, such as medication, need not be avoided because it is intrusive. Often, medications are the least restrictive alternative. It is not always easy to adjust the balance required by the least restrictive alternative requirement. The value of the concept is that it calls attention to the need to strike the balance.<sup>192</sup>

The application of least restrictive alternative analysis to managing a criminal defendant who is not *Dusky* competent to stand trial may require

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<sup>189</sup> See, e.g., *Dunn v. Blumstein*, 405 U.S. 330, 343 (1972) ("It is not sufficient for the State to show that duration residence requirements further a very substantial state interest. In pursuing that important interest, the State cannot choose means that unnecessarily burden or restrict constitutionally protected activity. . . . If there are other reasonable ways to achieve those goals with a lesser burden on constitutionally protected activity, a State may not choose the way of greater interference. If it acts at all, it must choose 'less drastic means.'") (quoting *Shelton v. Tucker*, 364 U.S. 479, 488 (1960)).

<sup>190</sup> *Shelton*, 464 U.S. at 488 (invalidating a statute requiring public school teachers to disclose all organizations to which they belong because "less drastic means for achieving the same basic purpose" are available). See also *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965) (governmental purpose "may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms.") (quoting *NAACP v. Alabama*, 377 U.S. 288, 307 (1963)).

<sup>191</sup> See *Antipsychotic Medication*, *supra* note 1, at 193.

<sup>192</sup> *Id.* In *Rennie*, Judge Brotman illustrated the least restrictive alternative requirement by pointing out that experts on both sides in the case had testified that Lithium combined with an antidepressant might be more efficacious and less harmful to Rennie than the Prolixin or Thorazine he had been compelled to receive. 462 F. Supp. 1131, 1146 (1978).



a determination of whether an alternate treatment method should at least be tried before using a more intrusive means such as antipsychotic medication. Verbal psychotherapy and behavioral modification techniques utilizing positive reinforcement<sup>193</sup> are both arguably less intrusive and, therefore, less restrictive of the liberty interests at stake than antipsychotic medication.<sup>194</sup> The effectiveness of these techniques in treating the psychiatric disorders causing trial incapacity is essential to deciding whether they are in fact alternatives; such a determination may need to be made on a case by case basis.<sup>195</sup> The least restrictive alternative may not require that the less intrusive option be as effective as the more intrusive treatment. Thus, it is not clear whether a determination that antipsychotic medications produce a higher level of trial competency than the alternate psychiatric techniques would shift the balance toward the use of drug therapy. It is at least arguably feasible, using the least restrictive alternative approach, that a trial judge should defer to an otherwise competent defendant's request not to receive antipsychotic medication for a test period, during which less intrusive therapy could be administered to achieve *Dusky* competency. If the defendant attains trial competency without antipsychotic medication, then he should be tried in such condition. However, if the less intrusive treatment methods fail to restore competency to stand trial within a reasonable period, then drug treatment may become the least restrictive alternative which may then be administered even if the defendant continues to object.

Some of the civil commitment cases involving incompetent adults reveal a reluctance to order treatment with antipsychotic drugs unless it can be determined that the patient, if competent, would consent.<sup>196</sup> Such a determination requires that a judge or guardian consider both the factors that the ward, if competent, would consider in deciding whether to consent to treatment, as well as any indications there may be as to what weight the ward would give to such factors.<sup>197</sup> Such a determination is called "substituted judgment"<sup>198</sup> and is distinguished from the choice a

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<sup>193</sup> At least when not placing the defendant in a state of deprivation at the outset of therapy.

<sup>194</sup> See Winick, *supra* note 5, at 813. A defendant could show that antipsychotic drugs were not the least restrictive alternative by reference to studies showing that "perhaps fifty percent of outpatient schizophrenics might not be worse off if their medications were withdrawn" as well as to "the increasing number of medical commentators calling for a reexamination of prolonged maintenance antipsychotic drug therapy and recommending periodic 'drug free holidays' to determine the feasibility of drug discontinuation." *Id.*

<sup>195</sup> If these techniques fail to affect trial competence, the state's concern that an accused is "using" the incompetency principles to avoid trial may be heightened; in such a scenario, antipsychotic drugs may become the least restrictive alternative. The state, however, may be required to *attempt* to strike the balance between avoidable intrusiveness and efficacy.

<sup>196</sup> See *Guardianship of Roe*, 383 Mass. 415, 421 N.E.2d 40 (1981); *Rogers v. Commissioner of Dep't of Mental Health*, 390 Mass. 489, 458 N.E.2d 308 (1983).

<sup>197</sup> See *In re Boyd*, 403 A.2d 744 (D.C. Ct. App. 1979).

<sup>198</sup> See *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 750-59, 370 N.E.2d 417, 430-35 (1977).

reasonable person might make or from one that is necessarily in the incompetent person's "best interests."<sup>199</sup> Thus, where there are indications that an incompetent would have, even if competent, refused a demonstrably beneficial course of treatment, judges have been unwilling to compel it<sup>200</sup> because of the patient's interest in freedom from nonconsensual invasion of his body.<sup>201</sup> Application of substituted judgment analysis to the mentally ill criminal defendant awaiting trial may require judicial assertion of the least restrictive doctrine where the accused is incompetent to raise the issue on his own.

Another alternative to forcibly medicating a mentally ill defendant to attain trial competency is to view a defendant's decision to refuse antipsychotic medication as a waiver in advance of his due process right to be tried while competent should the absence of medication cause decompensation. Such an alternative would address the state's concern that the incompetency doctrine not be abused by defendants to avoid trial altogether per the *Jackson v. Indiana*<sup>202</sup> decision; the trial would go on. Another justification for the insistence of a competent defendant, the need to protect the dignity and decorum of the trial process, could be met by allowing the trial judge to deal with such issues if and when they emerge. If a refusing defendant deteriorates off medication to the point where judicial decorum becomes a problem, a judge has the same sanctions available to him as with misbehavior at trial by non-mentally ill defendants.<sup>203</sup> If necessary, rather than being required to accept antipsychotic drugs to control behavior, the defendant could be excused from the courtroom for brief periods and the trial could continue in his absence.<sup>204</sup>

The state's valid interest in the accuracy and apparent fairness of the criminal process<sup>205</sup> should not be undermined to a greater extent by allowing the trial of a defendant who has refused to become competent through the use of antipsychotic drugs than it is by allowing the trial of

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<sup>199</sup> *Roe*, 383 Mass. at 434-35, 421 N.E.2d at 51-52. However, the preferences of the incompetent patient are not necessarily determinative; even if a guardian asserts his ward's unwillingness to accept antipsychotic drugs, the court may override the refusal if the ward is found to be dangerous. *Rogers*, 390 Mass. at 510, 458 N.E.2d at 321. See also Brooks, *supra* note 20, at 366.

<sup>200</sup> See, e.g., *Wentzel v. Montgomery Gen. Hosp.*, 293 Md. 685, 447 A.2d 1244 (1982).

<sup>201</sup> See *Saikewicz*, 373 Mass. at 728, 370 N.E.2d at 417.

<sup>202</sup> 406 U.S. 715 (1972). See *supra* notes 54-63 and accompanying text. If the defendant is not competent to waive his due process objection to trial while incompetent, then substituted judgment analysis should become relevant to determine if there is a waiver.

<sup>203</sup> The sanctions available avoid having to postpone the trial altogether. See *Illinois v. Allen*, 397 U.S. 337 (1970). Where necessary, the judge could declare a mistrial, even over the defendant's objection, without barring a future trial on the basis of double jeopardy. See *Hamm v. Jabe*, 706 F.2d 765, 767 (6th Cir. 1983).

<sup>204</sup> See *Allen*, 397 U.S. at 342-43; FED. R. CRIM. P. 43(b) & (c). The validity of the concern for avoiding criminal trials that threaten the decorum of the court is undercut by great tolerance of equivalent or worse conduct by patients in civil commitment hearings.

<sup>205</sup> See Note, *supra* note 48, at 457-58.

a defendant whose demeanor has been purposefully altered by the state through drug therapy. Indeed, the Massachusetts supreme court, when faced with a defense demand to be tried in an unmedicated state, held that the defendant had such a right because no expert description of the medication's effects on the defendant was an adequate substitute for the jurors actually seeing the accused in his unmedicated state.<sup>206</sup> The court considered the antipsychotic medication's effects on the defendant's demeanor both in ascertaining credibility and in determining the substantive issue of mental non-responsibility and held that, if the accused is willing to waive being tried while competent in order to present accurate demeanor testimony to the jury, he has the right to do so.<sup>207</sup> It seems reasonable to extend this ability to waive being tried while competent in order to avoid the acknowledged powerful side effects that the antipsychotics produce.

## VII. CONCLUSION

An examination of the case law and commentary on the right to refuse antipsychotic medication reveals that in the civil commitment area the right to refuse is granted more potency by the state decisions that have discussed the issue than by the federal courts which have retained more control in the hands of medical professionals.<sup>208</sup> Also revealed is a willingness, even among those courts recognizing a meaningful right to refuse antipsychotic drugs by a patient/prisoner, to emphasize in criminal cases the effect of the drugs in restoring competency to stand trial while giving less serious consideration to the medications' deleterious side effects. While the *Mental Health Standards* accepts that the state's goal in forcibly medicating in the criminal cases is different than that in the civil commitment cases, this distinction does not necessarily justify the conclusion that there should be no meaningful right to refuse for a criminal defendant who is mentally ill, while there is such a right for an involuntarily committed patient/prisoner. Valid alternatives to forcible medication with antipsychotics do exist to meet the concerns of the state even in the criminal trial context. Perhaps what is most revealed is that the entire area of the forcible use of antipsychotic medication in both the civil and criminal contexts would greatly benefit from direct and clear Supreme Court guidance.

BRIAN DOMB

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<sup>206</sup> *Commonwealth v. Louraine*, 390 Mass. 28, 35, 453 N.E.2d 437, 442 (1983).

<sup>207</sup> *Id.* at 38 n.13, 453 N.E.2d at 444 n.13.

<sup>208</sup> See *supra* notes 137-70 and accompanying text. This trend may reverse itself with the anticipated Supreme Court decision in *Harper v. State*, 110 Wash. 2d 873, 759 P.2d 385 (1988).