

01-1143

**UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT**

United States of America,
Appellee,

v.

Aaron Gomes (a.k.a. Lamont Keaton),
Defendant-Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

**BRIEF OF AMICUS CURIAE
AMERICAN PSYCHOLOGICAL ASSOCIATION**

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INTEREST OF AMICUS

This brief is submitted in response to the Court's order of July 24, 2001, inviting the American Psychological Association ("APA") to address certain issues relevant to the circumstances, if any, in which the Constitution permits the involuntary administration of antipsychotic medication to criminal defendants for the purpose of making them competent to stand trial.¹

APA is a voluntary, nonprofit, scientific, and professional organization with more than 155,000 members and affiliates. It has been the major association of psychologists in the United States since 1892, and it includes the vast majority of psychologists holding doctoral degrees from accredited universities in this country. APA has divisions devoted to psychopharmacology, clinical psychology, law and psychology, and other subjects germane to this case. APA members treat many individuals who have faced or may face criminal prosecution and who have been or may be imprisoned for various criminal offenses. APA members have a substantial professional interest in the appropriate use of antipsychotic drugs and other treatment modalities in that context. APA also has a broader ethical and professional interest in ensuring that people with mental illness are treated in a humane and beneficial manner.

¹ APA wishes to acknowledge the assistance of Michael Enright, PhD, Thomas Grisso, PhD, Kirk Heilbrun, PhD, and Morgan Sammons, PhD, in the preparation of this brief.

The Court’s order invited APA and three other organizations to submit briefs amicus curiae addressing ten questions of law, empirical fact, and expert opinion raised by this case. Instead of responding to the Court’s questions seriatim, APA has divided this brief into two major parts. The Scientific Background section addresses the state of drug-related treatments for psychosis, the range of side-effects associated with particular categories of drugs, and the efficacy of alternative, non-drug-related therapies for the victims of psychosis. The Argument section then proposes a legal framework for resolving disputes about the coercive administration of antipsychotic drugs as a means of making criminal defendants competent to stand trial. APA hopes that this structure will be useful to the Court.²

SCIENTIFIC BACKGROUND

I. THE BENEFITS AND SIDE EFFECTS OF ANTIPSYCHOTIC DRUGS.

Antipsychotic drugs³ are often effective in alleviating the psychotic symptoms of a number of mental disorders. See Philip Janicak et al., Principles

² APA has not addressed certain questions posed by the Court that call for answers outside APA’s expertise. E.g., Question 3 (regarding the nature of the government interest), Question 9 (regarding States’ approaches to the issues).

³ “Antipsychotic” drugs are typically grouped under the broader rubric of “psychotropic” drugs. “Psychotropic medications can include sedatives and tranquilizers . . . , hypnotics . . . , mood stabilizers . . . , antidepressants . . . , [and] antipsychotics.” David M. Siegel et al., Old Law Meets New Medicine: Revisiting Involuntary Psychotropic Medication of the Criminal Defendant, 2001 Wis. L. Rev. 307, 345.

and Practice of Psychopharmacotherapy 110-33 (2d ed. 1997); Bruce J. Winick, The Right to Refuse Mental Health Treatment 70 (1997) (hereinafter “Winick”). As the Supreme Court has observed, antipsychotic drugs achieve these results by “alter[ing] the chemical balance in a patient’s brain, leading to changes, intended to be beneficial, in his or her cognitive processes.” Washington v. Harper, 494 U.S. 210, 229 (1990).

Competence to stand trial is a legal standard, and is met where the defendant demonstrates “sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding,” and “a rational as well as factual understanding of the proceedings against him.” Dusky v. United States, 362 U.S. 402, 402 (1960) (per curiam). A criminal defendant may be incompetent to stand trial as a result of a number of different factors, including psychosis and other mental disorders. See generally Robert A. Nicholson & Karen E. Kugler, Competent and Incompetent Criminal Defendants: A Quantitative Review of Comparative Research, 109 Psychol. Bull. 355 (1991). Where an individual’s trial incompetence is a product of such mental disorders, antipsychotic drugs may be effective in alleviating the symptoms of the disorder, thereby helping the defendant to become competent.

Although antipsychotic drugs help many patients, a “substantial minority” of patients do not benefit from the drugs. Winick, supra, at 70. Moreover, the use of

antipsychotic drugs “is often accompanied by toxic reactions and adverse side effects, some of which are quite serious and irreversible.” Id. at 72; see Rafael A. Rivas-Vazquez et al., Atypical Antipsychotic Medications: Pharmacological Profiles and Psychological Implications, 31 Prof. Psychol.: Res. & Prac. 628, 629-30, 633-35 (2000). In any particular case, the precise result of administering antipsychotic drugs depends on factors such as the type of drug employed and the individual characteristics of the patient.

Antipsychotic drugs may be divided into two general categories: “conventional” drugs, and the more recently developed “atypical” drugs.⁴ Although both categories are generally effective in treating psychotic disorders, they carry varying risks of a range of side effects. Conventional antipsychotic drugs carry greater risks of more severe side effects, but atypical antipsychotics may cause serious side effects as well. Moreover, because atypical drugs are not yet available in injectable form and must therefore be administered orally, conventional antipsychotics are more likely to be used in situations where the patient does not wish to be medicated.

⁴ Conventional antipsychotic drugs include, among others, haloperidol (Haldol), thiothixene (Navane), chlorpromazine (Thorazine), and thioridazine (Mellaril). Atypical drugs include clozapine (Clozaril), risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), and ziprasidone (Geodon). See Physician’s Desk Reference (54th ed. 2000), at 2153-57 (Haldol), 2356-58 (Navane), 3050-52 (Thorazine), 1973-74 (thioridazine), 2008-2013 (Clozaril), 1453-57 (Risperdal), 1649-53 (Zyprexa), 562-66 (Seroquel).

A. Conventional Antipsychotic Drugs.

The side effects caused by conventional antipsychotic drugs are well documented in the scientific literature⁵ and have often been recognized by the courts.⁶

Common side effects include “extrapyramidal” reactions, a family of disorders including Parkinsonism, akathisia, dystonia, and tardive dyskinesia. See Thomas R.E. Barnes & J. Guy Edwards, The Side-Effects of Antipsychotic Drugs. I. CNS and Neuromuscular Effects, in Antipsychotic Drugs and Their Side-Effects 213, 217 (1993). Parkinsonism resembles the symptoms of Parkinson’s disease, and consists of muscular rigidity, resting tremors, motor retardation, a mask-like face, and pill-rolling hand movements. Id. at 214. Akathisia is a feeling of restlessness and a need to be in constant motion, causing the patient to pace and tap his foot incessantly. Id. at 223. Dystonia involves severe spasms of the head and neck muscles often accompanied by facial grimacing, involuntary spasms of the tongue and mouth, oculogyric spasms (which involve a brief, fixed stare, followed

⁵ See, e.g., Rivas-Vazquez et al., supra, at 629-30; Janicak et al., supra, at 188-217; Drug-Induced Dysfunction in Psychiatry 107-68 (Matcheri S. Keshavan & John S. Kennedy eds., 1992).

⁶ See, e.g., Riggins v. Nevada, 504 U.S. 127, 134 (1992); id. at 142-44 (Kennedy, J., concurring); Harper, 494 U.S. at 229-30; Mills v. Rogers, 457 U.S. 291, 293 n.1 (1982); United States v. Weston, 255 F.3d 873, 877 n.3 (D.C. Cir. 2001); Kulas v. Valdez, 159 F.3d 453, 455-56 (9th Cir. 1998), cert. denied, 528 U.S. 1167 (2000); United States v. Brandon, 158 F.3d 947, 954 (6th Cir. 1998).

by the eyes rolling upward for minutes at a time), bizarre posture and gait, and violent movement of the arms. Id. at 219.

Tardive dyskinesia is a “particularly pernicious” extrapyramidal reaction characterized by “involuntary, rapid, and jerky movements of facial and oral muscles, upper and lower extremities, and the trunk.” Rivas-Vazquez, supra, at 630; see Barnes & Edwards, supra, at 228-29. As a “tardive” condition, it tends to occur after prolonged administration of an antipsychotic drug, and may not even become evident until after the drug treatment has stopped. See Paul S. Appelbaum, Almost a Revolution 116 (1994); James B. Lohr, Tardive Dyskinesia, in Drug-Induced Dysfunction in Psychiatry 131 (Matcheri S. Keshavan & John S. Kennedy eds., 1992). Once it does develop, it is “potentially irreversible,” Rivas-Vazquez, supra, at 630, and in any event “may persist long after discontinuation of the antipsychotics” that caused it. See Lohr, supra, at 131. As the Supreme Court has observed, “a fair reading of the evidence . . . suggests that the proportion of patients treated with antipsychotic drugs who exhibit the symptoms of tardive dyskinesia ranges from 10% to 25%,” Harper, 494 U.S. at 230, though its incidence in older patients is much higher. See generally J.M. Kane, Tardive Dyskinesia: Epidemiology and Clinical Presentation, in Psychopharmacology: The 4th Generation of Progress 1485-95 (F.E. Bloom & D.J. Kupfer eds., 1995).

All these extrapyramidal symptoms can be “subjectively quite stressful, may be incompatible with clinical improvement and with a useful life outside the hospital, and can be more unbearable than the symptoms for which the patient was originally treated.” Winick, supra, at 73 (collecting scientific sources).⁷ Although the incidence of these side effects varies from patient to patient, there is general agreement that extrapyramidal reactions occur in approximately 50% to 75% of patients treated with conventional antipsychotic drugs, though some estimates are as high as 90%. See Rivas-Vazquez et al., supra, at 630.

Conventional antipsychotics may also cause a potentially fatal disorder known as “neuroleptic malignant syndrome.” Gerard Addonizio, Neuroleptic Malignant Syndrome, in Drug-Induced Dysfunction in Psychiatry 145, 145 (Matcheri S. Keshavan & John S. Kennedy eds., 1992). This relatively rare condition can, if not treated, lead to respiratory failure, cardiovascular collapse, and acute kidney failure. It is fatal in about 25% of cases in which it develops. See Winick, supra, at 74 & n.72 (collecting scientific sources).

Conventional antipsychotics also produce a range of other side effects, including sedation, interference with concentration, blurred vision, dry mouth and

⁷ Some of these reactions may be treated with additional drugs to counteract the side effects, but such treatment presents its own risks of additional adverse side effects, including blurred vision, memory lapses, and hallucinations. See generally J.K. Stanilla & G.M. Simpson, Treatment of Extrapyramidal Side Effects, in Textbook of Psychopharmacology 349 (Schatzberg & Nemeroff eds., 1998).

throat, constipation, urine retention, orthostatic hypotension (low blood pressure when standing), tachycardia (rapid beating of the heart), weakness, and dizziness. See Janicak et al., supra, at 201-03.

B. Atypical Antipsychotic Drugs.

Atypical antipsychotics generally “exhibit equal or improved therapeutic efficacy in comparison to the traditional or conventional agents, yet they have a more favorable side effect profile.” Rivas-Vazquez et al., supra, at 628. Each of these drugs, however, can cause potentially serious side effects.⁸

Clozapine, one of the most commonly prescribed atypical drugs, has been described as “the ‘gold standard’ for atypical agents.” Id. at 634. It nonetheless presents a risk of agranulocytosis, a potentially fatal disappearance of white blood cells. See Janicak et al., supra, at 206-07. Evidence suggests that agranulocytosis occurs in 2% of patients receiving clozapine. See Robert M. Wettstein, Legal Aspects of Prescribing, in Drug-Induced Dysfunction in Psychiatry 9, 16 (Matcheri S. Keshavan & John S. Kennedy eds., 1992). It is possible to monitor patients for this syndrome and to discontinue administration of the drug before the condition becomes too grave, but such monitoring is a demanding process, requiring weekly

⁸ For further discussion of atypical antipsychotic drugs, see A. Tuunainen et al., Newer Atypical Antipsychotic Medication Versus Clozapine for Schizophrenia, 2 Cochrane Database of Systematic Reviews pCD000966 (2000).

or even twice weekly blood tests for the initial six months of treatment. See Janicak et al., supra, at 206.

Other atypical drugs subject patients to relatively low risks of other serious side effects. Risperidone and olanzapine both carry a risk of producing certain extrapyramidal reactions when used in elevated dosages, id. at 192-94, while quetiapine can cause cataracts. See Rivas-Vazquez, supra, at 634-35. Atypical agents can also cause a range of other side effects, such as sedation, seizures, hypotension, and weight gain. Id. at 633-35. Moreover, because atypical antipsychotic drugs have been in widespread use for a comparatively short time, it is possible that they may also cause some late-onset side effects that have not yet been reliably identified, but that may begin to appear at some stage in the future.

At present, atypical drugs must be administered orally; they are not available in injectable form. See Paul A. Nidich & Jacqueline Collins, Involuntary Administration of Psychotropic Medication: A Federal Court Update, 11 No. 4 Health Law. 12, 13 n.21 (1999); United States v. Weston, 255 F.3d 873, 886 n.7 (D.C. Cir. 2001).⁹ Thus, when a patient is unwilling to receive antipsychotic medication, the administration of atypical drugs may not be practicable. Rather,

⁹ The Food and Drug Administration recently recommended FDA approval of injectable intramuscular formulations of olanzapine and ziprasidone. See Kenneth J. Bender, Injectable Atypical Antipsychotics Recommended, Psychiatric Times, May 2001, at 58. FDA has not yet finally approved such formulations of those drugs, however, and atypical antipsychotics continue to be available only in orally administrable form.

because conventional antipsychotics are available in forms that make forcible administration possible, those drugs are more likely to be used in such cases. See Peter F. Buckley, The Role of Typical and Atypical Antipsychotic Medications in the Management of Agitation and Aggression, 60 J. Clinical Psychiatry 52, 55, 57 (1999). The forcible administration of such drugs typically involves physically restraining the patient and then using a hypodermic needle to inject the drug.

C. Individual Variation in Effects of Antipsychotic Drugs.

Although both the efficacy and the side effects of antipsychotic drugs are often discussed in general terms, different patients can have vastly different reactions to any given drug. See Janicak et al., supra, at 110. The propriety of prescribing a given drug to a particular patient depends on a number of case-specific factors.

The patient's medical history, including whether he has been medicated with antipsychotic drugs in the past, can affect the success of future medication. Id.; see Weston, 255 F.3d at 883. Individual factors can also affect the likelihood that antipsychotic drugs will cause serious side effects. Tardive dyskinesia, for example, is far more likely to occur and to persist in older patients, especially elderly women. See Lohr, supra, at 131-33. Patients with mood disorders (such as depression) may be more likely to develop tardive dyskinesia than patients with

schizophrenia, and the risk is also increased for patients with other unrelated medical conditions such as diabetes. Id.

II. NON-DRUG ALTERNATIVES TO ANTIPSYCHOTIC DRUGS.

Although antipsychotic drugs are often greatly beneficial for patients with psychotic and other mental disorders, there is also a well-documented tendency to overprescribe such drugs for certain conditions. See Winick, supra, at 76-85. One consequence of this strong preference for medication is that alternative, non-drug therapies do not receive adequate consideration, even though non-drug therapies are generally far less intrusive on the patient's mind and body. See, e.g., Marnie E. Rice & Grant T. Harris, The Treatment of Mentally Disordered Offenders 3 Psychol., Pub. Pol'y & L. 126, 140 (1997); see infra at 22-24 (discussing the constitutional requirement of considering whether less intrusive means are available).

In fact, however, behavioral and psychosocial therapies are often effective in treating certain aspects of psychosis, including aggressive behavior.¹⁰ See, e.g.,

¹⁰ Behavioral therapy generally involves the teaching of adaptive, desirable behavior and the discouragement of maladaptive, undesirable behavior by altering the patient's environment and assigning consequences (positive and negative) to the patient's actions. See generally Winick, supra, at 41-59. Psychosocial therapy generally involves the application of psychological therapeutic techniques in group settings, with the goal of changing the individual's interpersonal skills through controlled group interaction. Id. at 32-35. It involves "teaching a mentally ill patient the additional skills to permit him or her to behave and interact in a relatively nonpathological manner, despite the continued existence of the

Shirley M. Glynn et al., Compliance with Less Restrictive Aggression-Control Procedures, 40 Hosp. & Comm. Psychiatry 82 (1989). Although such therapies are often not adequate by themselves to treat acute psychotic disorders, they may often be effective when employed along with antipsychotic drugs. Indeed, “[t]here can be no doubt as to the complementary merits of pharmacotherapy and structured, practical and educationally oriented psychosocial therapies in treating and rehabilitating persons with serious mental illnesses.” Robert Paul Liberman et al., Psychiatric Rehabilitation, in 2 Comprehensive Textbook of Psychiatry/VI 2696, 2715 (Harold I. Kaplan & Benjamin J. Sadock eds., 6th ed. 1995).

Consideration of psychosocial or other non-drug therapies is particularly important where, as here, the specific therapeutic goal is rendering an individual competent to develop functional abilities or social skills, such as assisting his attorney during a criminal trial. Antipsychotic drugs are not designed specifically to develop abilities and skills at all. Rather, they are intended to alleviate psychotic and other mental disorders. And while psychosis may contribute to the incompetence of some individuals to stand trial, trial incompetence serious mental disability are two distinct, though overlapping, categories. See Alex M. Siegel & Amiram Elwork, Treating Incompetence to Stand Trial, 14 L. & Human Behavior 57, 58 (1990).

underlying illness.” Kirk Heilbrun et al., The Debate on Treating Individuals Incompetent for Execution, 149 Am. J. Psychiatry 596, 602 (1992).

Psychosis and other mental disorders are defined scientifically in terms of their underlying causes and symptoms. Competence to stand trial, however, is a legal concept, and refers to functional abilities. Thus, a defendant is competent to stand trial if he demonstrates “sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding,” and “a rational as well as factual understanding of the proceedings against him.” Dusky, 362 U.S. at 402; see United States v. Nichols, 56 F.3d 403, 410 (2d Cir. 1995). The presence of psychosis does not necessarily mean the absence of these functional abilities, see Nicholson & Kugler, supra, at 356, and alleviating psychosis in individuals who do lack those abilities does not necessarily restore them. Thus, determining the appropriate treatment (if any) for attempting to restore a defendant’s competence to stand trial must take account of treatments designed specifically to address trial incompetence.

It is here that non-drug-oriented psychological approaches, including psychosocial and psychoeducational therapies and other treatment modalities, may be most useful.¹¹ See, e.g., Heilbrun et al., supra, at 602 (“The connection between [psychosocial rehabilitation] and competency-relevant behavior seems potentially strong.”). Because these kinds of treatment can be designed specifically to address

¹¹ Psychoeducational therapies can be defined as specific interventions designed to teach individuals about specific social or other settings, in order to maximize the individual’s ability to perform appropriately in such settings. See, e.g., Siegel & Elwork, supra, at 59.

trial incompetence, they may be able to achieve targeted results better than antipsychotic medication alone. Indeed, the scientific literature includes discussions of innovative and evidently successful non-drug therapies for defendants found incompetent to stand trial. See David B. Wexler & Bruce J. Winick, Therapeutic Jurisprudence and Criminal Justice Mental Health Issues, 16 *Mental & Physical Disability L. Rep.* 225, 228 (1992).

In one study involving “experimental treatment focused solely on behaviors related to incompetence to stand trial,” a group of incompetent patients were engaged in group therapy devoted to problem-solving techniques relevant to trial competence issues and were also given psychoeducational therapy designed to prepare and familiarize them with the trial process. Siegel & Elwork, supra, at 60. Those therapies led to significant increases in the patients’ scores on tests used to evaluate trial competence and greatly increased the chances of restoring competence after a relatively short period of time. For example, 45 days after one such experiment was completed, those who had received the cognitive and psychoeducational therapies were approximately three times more likely to be found competent to stand trial than those who had not. Id. at 62-63.

This is not to suggest that non-drug therapies alone are always the best way to restore individuals’ competence to stand trial. Although certain forms of psychosocial therapy by themselves may indeed be the most appropriate form of

treatment in some instances, in others the presence of acute psychosis may require a combined approach, involving both antipsychotic drugs and psychotherapeutic treatment. Not only will such combined approaches often be the most effective, they may also make it possible for lower drug doses to be used and for the course of drug therapy to be shortened. See Winick, supra, at 322; cf. Rivas-Vazquez et al., supra, at 637 (noting the “synergistic possibilities” provided by coupling psychotherapeutic interventions with atypical antipsychotic drugs).

SUMMARY OF ARGUMENT

This case involves weighing the government’s interest in bringing a defendant to trial against two distinct constitutional interests of the defendant: his core liberty interest in controlling what happens to his body, and his Fifth and Sixth Amendment rights to a fair trial. APA takes no position on the weight, in this balance, of the government’s interest in subjecting a psychotic defendant to trial. On the assumption that this interest is sufficiently weighty in some instances, the government should be permitted to compel medication of a defendant against his will only if it can make at least the following showings on the facts of a particular case: that the administration of the drugs in question is therapeutically appropriate for the specific defendant; that those drugs are substantially likely to render that defendant competent to stand trial; and that less intrusive non-drug alternatives would likely be ineffective in accomplishing the same objective.

I. These inquiries should be conducted on a case-by-case basis, with expert assistance, taking into account the specific characteristics of the individual and the likely effects and side effects of drug treatment on that individual. They should also involve consideration of non-drug psychological therapies specifically designed to address trial competence. Unless expert evidence definitively rules out the possible efficacy of such less intrusive treatments, they should be attempted first (either alone or in combination with lower drug doses) before any decision is made to rely solely on involuntary medication.

II. If the government succeeds in persuading a court to permit involuntary medication of a criminal defendant, it should be permitted to proceed to trial against that defendant only if he has become competent and the government can further show that the drugs would not themselves materially impair the defendant's ability to present an effective defense. The threat of such impairment can take several forms. First, antipsychotic medication can cause side effects that could affect the defendant's courtroom appearance and demeanor in a way that might prejudice the jury against him. Other side effects, such as sedation, might interfere with the defendant's ability to participate effectively in his defense. Moreover, the intended effect of the drugs -- alleviating psychosis and restoring competency -- might impair the defendant's ability to raise certain defenses at trial, such as insanity. All these risks can best be evaluated by the trial court at the time of trial.

While there may be ways to respond to and mitigate each of the problems should they arise, it is also possible that the court will conclude that a fair trial is not possible so long as the defendant is medicated.

ARGUMENT

I. FORCIBLE ADMINISTRATION OF ANTIPSYCHOTIC DRUGS TO RESTORE COMPETENCE SHOULD BE PERMITTED ONLY IF IT IS THERAPEUTICALLY APPROPRIATE, SUBSTANTIALLY LIKELY TO RESTORE COMPETENCE, AND THE LEAST INTRUSIVE MEANS OF ACHIEVING THAT PURPOSE.

The forcible administration of antipsychotic drugs carries profound consequences for the patient. As discussed, such drugs can have a powerful altering effect on patients' mental processes; they carry substantial risks of potentially severe side effects; and their administration may require physical restraint and forcible injection. These effects constitute "serious intrusions into the body and mind, directly affecting mental processes and imposing severe and often long-lasting physical side effects." Bruce J. Winick, The MacArthur Treatment Competence Study: Legal and Therapeutic Implications, 2 Psychol., Pub. Pol'y & L. 137, 147 (1996).

Thus, as the Supreme Court has recognized, "[t]he forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty." Harper, 494 U.S. at 229; see Riggins v. Nevada, 504 U.S. 127, 134 (1992). This interference is a function both of

antipsychotic drugs’ intended effect of “alter[ing] the chemical balance in a patient’s brain, leading to changes, intended to be beneficial, in his or her cognitive processes,” and of their potential for “serious, even fatal, side effects.” Harper, 494 U.S. at 229. The Court has accordingly observed that patients possess a “significant liberty interest in avoiding the unwanted administration of antipsychotic drugs,” id. at 221, and has found protection for that interest in the Due Process Clause. See Riggins, 504 U.S. at 134.

Although the Supreme Court has not explicitly defined the precise nature of the constitutionally protected liberty interest implicated by the forced administration of antipsychotic drugs, the interest certainly includes “bodily integrity, personal security and personal dignity.” Chambers v. Ingram, 858 F.2d 351, 359 (7th Cir. 1988); see United States v. Brandon, 158 F.3d 947, 953 (6th Cir. 1998) (“[F]orced medication implicates [a] Fifth Amendment liberty interest in being free from bodily intrusion”). The individual’s firmly embedded common law “right to determine what shall be done with his own body,” Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 129 (1914) (Cardozo, J.), is surely one of the personal rights that can be deemed fundamental or “implicit in the concept of ordered liberty,” Palko v. Connecticut, 302 U.S. 319, 325 (1937) (Cardozo, J.) (internal quotation omitted), and is therefore protected by the Due Process Clause.

The Supreme Court has not yet determined the precise level of judicial scrutiny that is appropriate for reviewing a government request to override a patient’s refusal to accept antipsychotic medication, see Riggins, 504 U.S. at 136, but its decisions quite clearly “suggest[] some form of heightened scrutiny.” Weston, 255 F.3d at 880. The Court has emphasized the need for an “overriding justification and a determination of medical appropriateness,” Riggins, 504 U.S. at 135, and has disapproved forced administration of antipsychotic drugs unless the government can carry its burden of proving that such administration is both therapeutically appropriate and “necessary to accomplish an essential state policy.” Id. at 138 (emphasis added).¹²

A. Forced Administration of the Drug Must be Therapeutically Appropriate.

As a threshold matter, administration of an antipsychotic drug must be therapeutically appropriate in a given case before it can be compelled; if such treatment is not therapeutically appropriate, it may not be forced on the defendant, even if doing so is necessary to achieve an essential government policy. See Riggins, 504 U.S. at 135 (finding forcible administration of antipsychotic drugs

¹² APA takes no position on the circumstances in which the government’s interest in prosecuting a defendant constitutes an “essential” state policy for these purposes, but we note that courts should weigh that policy differently depending on the gravity of the charged offense. See generally Weston, 255 F.3d at 881 (evaluating the government’s interest in light of the particular offense involved); Brandon, 158 F.3d at 960-61 (same).

“impermissible absent a . . . determination of medical appropriateness.”); United States v. Morgan, 193 F.3d 252, 264 (4th Cir. 1999) (“[D]ue process would require the district judge to make findings as to the . . . ‘medical appropriateness’ of such medication”).

For an antipsychotic drug to be deemed therapeutically appropriate, it should be substantially likely to achieve the treatment goals for which it is designed (generally, the mitigation of psychotic symptoms) and should not carry an undue risk of severe side effects. These two factors should be balanced against one another: the less likely a drug is to be effective, the more the risk of side effects weighs against its administration. Indeed, “[t]he neurological side effects of the antipsychotic drugs, particularly tardive dyskinesia, call for a . . . careful balancing in individual cases of the risks associated with their long-term use against anticipated benefits.” Winick, supra, at 83.

Moreover, because both the efficacy and the side effects of any particular antipsychotic drug may vary from case to case, therapeutic appropriateness must be determined on a case-by-case basis. Thus, the fact that a particular drug is the generally preferred treatment for the defendant’s condition is not, by itself, sufficient to establish that its administration is therapeutically appropriate in that particular case.

Finally, as a procedural matter, although the determination whether a proposed course of treatment is therapeutically appropriate depends on the judgment of qualified professionals, courts should still take care to inquire into the basis of such expert judgments. In Harper, for example, the Court acknowledged its limited ability “to determine whether, on the basis of isolated parts of respondent’s medical records, the care given to him is consistent with good medical practice.” 494 U.S. at 230 n.12. The Court did not, however, suggest that courts should accept the assertions of therapeutic propriety uncritically. Rather, it treated the matter in the way it treats other questions of fact, and “defer[red] to the finding of the trial court . . . that the medical care provided to respondent was appropriate under medical standards.” Id. The trial court was responsible for making the initial finding of therapeutic appropriateness, based on its assessment of the evidence presented. See id. at 227 n.11. Thus, it is appropriate for the courts -- especially the trial courts -- to examine assertions that administering antipsychotic drugs is therapeutically appropriate in any given case, and to ascertain whether such treatment is consistent with the standard of care in the relevant professional community. See Rickman v. Dutton, 864 F. Supp. 686, 712-15 (M.D. Tenn. 1994) (finding no therapeutic justification for forcible administration of antipsychotic drugs to defendant during trial), aff’d, 131 F.3d 1150 (6th Cir. 1997), cert. denied, 523 U.S. 1133 (1998).

B. The Drug Must be Substantially Likely to Accomplish the Goal Justifying its Forced Administration -- Trial Competence -- and Necessary to Achieve that Goal.

Even if antipsychotic drugs are likely to mitigate a patient's psychotic symptoms, a court should find them to be therapeutically appropriate only if trial competence is substantially likely to result. This analysis requires distinguishing between the therapeutic goals of treatment, on the one hand, and the government's interest in obtaining the legally defined outcome of trial competence, on the other.

As discussed above, see supra at 12-13, antipsychotic drugs are not designed to address the specific problem of trial incompetence. Rather, they are intended to address potentially related, but distinct, problems of psychosis and other mental disorders. To justify their forced administration for the purpose of restoring a defendant's trial competence, the government must be able to show that, in a particular case, the defendant's incompetence is sufficiently related to his psychosis or other mental disorder that medication targeted at the psychological condition is substantially likely to achieve the legal outcome it seeks.

Moreover, the administration of antipsychotic drugs in their proposed dosage must also be "necessary" to render the defendant competent to stand trial. Riggins, 504 U.S. at 138. This requirement demands that the use of medication be narrowly tailored to achieve the government's purpose and that it be the least intrusive means of doing so. See Brandon, 158 F.3d at 960. Such "narrow

tailoring” need not entail a perfect correspondence between the means chosen and the government’s desired end, but it should involve a consideration of all reasonably available and less intrusive methods capable of accomplishing that end. See Dunn v. Blumstein, 405 U.S. 330, 343 (1972).

In this context, the narrow tailoring analysis involves assessing the extent of the intrusion that forcible administration of antipsychotic drugs would likely pose on the particular defendant, and then inquiring into the availability of any less intrusive, but still effective, alternatives. The coercive administration of antipsychotic drugs is profoundly intrusive, and is almost always more intrusive than the use of non-drug psychological therapies. See Winick, supra, at 320-23. And while non-drug therapies may not be effective by themselves in treating all patients with severe psychotic disorders, there is, as noted above, evidence to suggest that some forms of psychosocial, psychoeducational, and other modalities of therapy may be effective in helping to restore competence to stand trial. See supra at 11-15. Indeed, there are forms of psychological therapy that can be specifically targeted at problems of trial incompetence, such as group therapy focused on problem solving and other cognitive developmental issues, and psychoeducational approaches aimed at familiarizing the individual with the courtroom setting and enabling him to act appropriately in it. See generally, e.g., Siegel & Elwork, supra.

Courts should thus be reluctant to conclude that medication alone is the least intrusive method that is substantially likely to succeed in achieving trial competence. In particular, “[w]here the expert testimony does not clearly eliminate the possibility that other [non-drug] approaches may be efficacious, . . . they should be attempted in an effort to determine whether medication is truly necessary to maintain the defendant’s competency.” Winick, supra, at 322. In addition, even if non-drug treatments are unlikely to succeed on their own, “their combination with medication might enable a lower dose of medication to be used, resulting in less intrusiveness, a lesser burden on constitutional values, and less risk of severe side effects.” Id.¹³

II. THE FORCED ADMINISTRATION OF ANTIPSYCHOTIC DRUGS MAY ALSO COMPROMISE THE DEFENDANT’S FIFTH AND SIXTH AMENDMENT RIGHTS TO A FAIR TRIAL.

The coercive administration of antipsychotic drugs may also compromise a defendant’s Fifth and Sixth Amendment rights to a fair trial. See Riggins, 504 U.S. at 136-38.

¹³ In cases where the government fails to make the necessary showing to justify forcible administration of antipsychotic drugs and where non-drug treatment proves ineffective in restoring trial competence, the Constitution imposes significant conditions on the continued detention of the defendant, particularly where, as here, the defendant has not been shown to pose a danger to himself or others. See Jackson v. Indiana, 406 U.S. 715 (1972).

A. The Side Effects of Antipsychotic Drugs May Threaten the Defendant's Fair Trial Rights.

The first set of risks involves the various side effects associated with antipsychotic drugs. Justice Kennedy has suggested that “[t]he drugs can prejudice the accused . . . by altering his demeanor in a manner that will prejudice his reactions and presentation in the courtroom,” so that he will appear unsympathetic to the jury or even the judge. Riggins, 504 U.S. at 142 (Kennedy, J., concurring). Restlessness, Parkinsonian tremors, muscle spasms, and slurred speech -- among other side effects -- all could adversely affect the jury’s opinion of a defendant. See Riggins, 504 U.S. at 142-43 (Kennedy, J., concurring).

Additionally, as suggested above, see supra at 8-9, antipsychotic drugs can “flatten or deaden [the recipient’s] emotional responses,” United States v. Weston, 206 F.3d 9, 20 (D.C. Cir. 2000) (Tatel, J., concurring), making him look “so calm or sedated as to appear bored, cold, unfeeling, and unresponsive.” Riggins, 504 U.S. at 143 (Kennedy, J., concurring) (quoting Br. for American Psychiatric Association). Such alterations in the defendant’s appearance can cause “serious prejudice . . . if [the] medication inhibits the defendant’s capacity to react and respond to the proceedings and to demonstrate remorse or compassion.” Id. at 143-44.

Finally, the side effects associated with antipsychotic drugs may undermine the defendant’s ability to participate effectively in his own defense by dulling his

cognition, see supra at 8-9, and thus compromising his “interaction with counsel, or his comprehension at trial.” Riggins, 504 U.S. at 138. Recognizing this risk, the Court in Riggins found “a strong possibility that [the defendant’s] defense was impaired” in this manner, even though the principal side effects the Court considered were relatively minor -- drowsiness, confusion, and feeling “uptight.” Id. at 137.

The extent of the interference with a defendant’s right to a fair trial in any particular case depends on the severity of the side effects. Accordingly, these concerns are probably best addressed at the time of trial, after the drugs have already been administered and their effects in the given case are understood. The trial court will then be in the best position to determine the precise effects of the medication and the likely impact of those effects on the defendant’s fair trial rights. See Weston, 255 F.3d at 886 n.8 (“Whether antipsychotic medication will impair [the defendant’s] right to a fair trial is best determined when the actual effects of the medication are known, that is, after he is medicated.”).

If, at the time of trial, the court determines that the antipsychotic drugs have caused side effects that are likely to impair the defendant’s right to a fair trial, the court may conclude that he simply cannot be tried while medicated. Alternatively, the court may attempt to instruct the jury about the defendant’s medication and its effects, and admonish the jury not to draw adverse inferences about the defendant

based on his appearance and demeanor. See Weston, 255 F.3d at 886. Whether such instructions would be effective is unclear; substantial empirical evidence suggests that judges' instructions to juries to disregard evidence before them are generally ineffective. See J. Alexander Tanford, The Law and Psychology of Jury Instructions, 69 Neb. L. Rev. 71, 95 (1990).¹⁴ Courts should therefore examine carefully the likely prejudice to the defendant's trial rights, and proceed to trial only if it is clear that those rights will not be intolerably burdened. See Riggins, 504 U.S. at 145 (Kennedy, J., concurring).

B. The Intended Effect of Antipsychotic Drugs May Undermine the Defense.

Finally, the intended effects of administering antipsychotic drugs -- alleviating psychotic symptoms and restoring competence to stand trial -- may compromise the defendant's ability to raise certain defenses at trial. In particular, rendering a previously psychotic and delusional individual competent may impair his ability to mount an effective insanity defense by removing the best evidence of that insanity: the physical manifestations of the defendant's own mental state.

Of course, a defendant rendered competent by the administration of antipsychotic drugs is still free to mount an insanity defense if he so wishes. He

¹⁴ As Justice Jackson observed, "[t]he naive assumption that prejudicial effects can be overcome by instructions to the jury, . . . all practicing lawyers know to be unmitigated fiction." Krulewitch v. United States, 336 U.S. 440, 453 (1949) (Jackson, J., concurring).

might do so by relying on the testimony of psychiatrists or other therapists who treated him before he was medicated, by testifying himself about the nature of his unmedicated mental state, or by introducing a videotape recording of himself prior to the administration of the medication.

Still, none of these alternatives is likely to be as effective as the defendant's testimony and courtroom presence while in his unmedicated state. Empirical research shows that jurors who think the accused is displaying psychotic symptoms at the time of trial are significantly more likely to return a verdict of not criminally responsible on account of mental disorder than are those who think the accused is symptom-free during the trial. See Karen E. Whittemore & James R.P. Ogloff, Factors That Influence Jury Decision Making: Disposition Instructions and Mental States at the Time of the Trial, 19 L. & Hum. Behav. 283, 292 (1995). Cf. Weston, 206 F.3d at 21 (Tatel, J., concurring).

In its most recent Weston decision, the D.C. Circuit dismissed this concern on the ground that “a defendant does not have an absolute right to replicate on the witness stand his mental state at the time of the crime.” 255 F.3d at 884. In particular, the court observed that “[a] defendant asserting a heat-of-passion defense to a charge of first degree murder does not have the right to whip up a frenzy in court to show his capacity for rage.” Id. But there is a fundamental difference between the government's interest in preserving courtroom decorum by

preventing an otherwise competent defendant from “whip[ping]” himself into a “frenzy” and its authority to fundamentally alter a defendant’s psychological status quo by forcing drugs on him. As Judge Tatel explained in an earlier stage of the Weston case, “the question [here] is whether due process permits the government through involuntary administration of psychotropic drugs to alter the defendant so that it becomes impossible for him to appear before the jury as he was when he committed the crime.” 206 F.3d at 21-22 (Tatel, J., concurring).

A more appropriate analogy may be the rule of Brady v. Maryland, 373 U.S. 83 (1963), which prohibits the government from concealing from the defense evidence favorable to the accused. Here, it could be said that the government is concealing evidence favorable to the defendant by intentionally altering the defendant’s current mental state, which he hopes to use as evidence of his mental state at the time of the offense.

As with the risk of unfair trial prejudice caused by the side effects of antipsychotic drugs, concern about a defendant’s ability to mount an effective defense of insanity or impairment is best addressed at the time of trial. The trial court will be able to consider the defenses the defendant proposes to mount, and, to the extent any of them involve claims about the defendant’s mental state at the time of the offense, assess whether there are alternative ways for the defendant effectively to mount the defense. If the court concludes an effective defense

cannot be mounted so long as the defendant is medicated, it should not proceed with the trial. Cf. Riggins, 504 U.S. at 145 (Kennedy, J., concurring).

CONCLUSION

For the foregoing reasons, antipsychotic drugs should not be forcibly administered to a criminal defendant for the purpose of rendering him competent to stand trial unless the government can prove that administration of the drugs in question is therapeutically appropriate for the specific defendant; that the drugs are substantially likely to render the defendant competent to stand trial; and that less intrusive non-drug alternatives would likely be ineffective in accomplishing the same objective. Moreover, once antipsychotic drugs are administered and the defendant is brought to trial, the government should be required to show that the drugs will not materially impair the defendant's ability to present an effective defense.

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