Forced Medication after *U.S. v. Sell*: Fighting Your Client's "War on Drugs"

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I. What happened in *Sell*?

The landscape of forced medication cases changed significantly as the result of the struggle of Dr. Charles Thomas Sell. Dr. Sell had a thriving dental practice in suburban St. Louis when, in 1997, he was indicted on over sixty counts of fraud and money laundering related to his practice.[1] After the first indictment, a witness in the case made allegations that Dr. Sell had threatened her life; another informant claimed Dr. Sell was making plans to kill an F.B.I. agent involved in the investigation. Thus, in April of 1998, the government obtained another indictment against Dr. Sell, adding those serious charges.

Dr. Sell had a history of mental illness dating back to 1982. Questions regarding competency were inevitably raised, and in early 1999, the magistrate entered an order sending Dr. Sell to the United States Medical Center for Federal Prisoners in Springfield, Missouri ("Springfield"). The doctors at Springfield believed he was suffering from Delusional Disorder and determined he was not competent to stand trial. The federal magistrate then ordered that Dr. Sell be "hospitalized for medical treatment" at Springfield for up to four months to determine if he could be restored to competency.

The staff at Springfield quickly decided that the only way to restore Dr. Sell to competency would be through the use of powerful anti-psychotic medications. However, he did not believe he had a problem that needed medicating. Moreover, given his medical background, he well knew that these drugs could have serious, permanent, even life-threatening side-effects. Therefore, he adamantly refused the drugs. Consequently, Springfield staff took steps to force the drugs upon him.[2]

In Dr. Sell's words, they did everything they could to "make his life a living hell" until he agreed to take the drugs.[3] They determined he was "dangerous" when he took a liking to a staff nurse and addressed her by her first name. Moving him from

an "open" ward where he had many privileges and virtually unrestricted movement, he was placed in solitary confinement. Dr. Sell complained he suffered serious physical abuse at the hands of the Springfield guards. For example, he alleged that the guards stripped him, sprayed him with scalding water, and dragged him, nearly naked, in handcuffs, through the corridors of the institution. Some dismissed these allegations as the fantasy of a delusional mental patient; however, his lawyers eventually uncovered institutional video recordings that captured the abuse and substantiated his claims.[4]

Dr. Sell never backed down from his staunch refusal to take antipsychotics, and neither did his lawyers.[5] After much litigation in lower courts, the Supreme Court agreed to hear his case, to answer the question "whether the Constitution permits the Government to administer antipsychotic drugs voluntarily to a mentally ill criminally defendant– in order to render that defendant competent to stand trial for serious, but nonviolent crimes."[6] The result was a landmark decision that required the government to make a substantial showing before it could proceed with forced medication of an incompetent defendant.

The Court remanded the case to the District Court for further proceedings under the tests set forth in the *Sell* decision, but no further attempts were made to force medicate him. In 2005, after nearly seven years of fighting off forced medication, he was finally deemed competent to enter into a plea agreement. He plead no contest to the charges and was sentenced to time served and supervised release. He received (non-drug) therapeutic treatment from Dr. Robert Cloninger, the defense expert in his case.[7] As of this writing, his Delusional Disorder is in remission, and he is living a quiet, normal life in Missouri .

A. What is the *Sell* holding?

The Supreme Court framed the issue as a conflict between individual autonomy rights and the Government's right to intrude on those in criminal competency restoration. It framed the issue as: "[h]as the Government, in light of the efficacy, the side effects, the possible alternatives, and the medical appropriateness of a particular course of antipsychotic drug treatment, shown a need for that treatment sufficiently important to overcome the individual's protected interest in refusing it?"[8] The Court answered that the Constitution would allow forced medication under the following, limited circumstances:

(1) There must be "*important governmental interests*" at stake. This

means that the charges must be "serious," and that "special circumstances" may lessen the importance of that interest.

(2) Involuntary medication must "*significantly further*" the important governmental interest. This means that:

(A) the "administration of the drugs must be *substantially likely* to render a defendant competent to stand trial;" and,

(B) the administration of drugs must be "*substantially unlikely*" to have side effects that will undermine the trial's fairness or significantly interfere with the defendant's ability to assist counsel in conducting a defense. This is the issue raised by Justice Kennedy in his *Riggins v. Nevada* concurrence that becomes a central part of the majority holding in *Sell*.

(3) Involuntary medication must be "*necessary* to further those interests." This means there are no likely *alternative, less intrusive* means to achieve substantially same results.

(4) Finally, the involuntary medication must be "*medically appropriate.*" It must be "in the patient's best medical interest in light of his medical condition." This prong examines issues such as side-effects, efficacy of using specific drugs to treat specific conditions, and available medical research.[9]

Because the Court views these standards as rigorous protections, it notes that instances of involuntary medication "may be rare."[10]

B. What was the *Riggins* concurrence that was relied on in *Sell*?

Riggins preceded *Sell* by eleven years. In *Riggins*, the pre-trial defendant was medicated with an antipsychotic drug, Mellaril, to render him competent for trial. He moved to suspend that treatment for trial, arguing that it interfered with his Due Process rights to show the jury his present demeanor as well as his mental state when unmedicated. His motion was summarily denied, and he went to trial on capital charges with an insanity defense; having testifying at trial while medicated, he was convicted and sentenced to

death.[11] The Supreme Court held that this violated his Sixth and Fourteenth Amendment rights. He was entitled to a hearing regarding forced administration of the drugs.[12] However, the more intriguing Eighth Amendment question, that is the right to show the jury what he looked like when unmedicated, had not been preserved. So the *Riggins* majority did not address it.[13] In his concurrence, Justice Kennedy seized on that issue, considering it an important trial right.[14] The *Riggins* Kennedy concurrence became a central pillar of the *Sell* holding.[15]

C. What constitutional protections are implicated by *Sell*?

1. Substantive Due Process: The Supreme Court found that *substantive* Due Process may prevent the government from interfering with a defendant's medical decision about how to treat his mental illness.[16] This right is also referred to as a right to personal autonomy, privacy, and freedom from bodily intrusions.[17] For federal prosecutions, it is embodied in the Fifth Amendment to the United States Constitution; for state prosecutions, that federal protection is imposed through the Fourteenth Amendment. This right was also, incidentally, the constitutional basis for the related *Riggins* decision.[18]

2. Procedural Due Process: Aside from personal liberty interests, the criminal defendant's right to a fundamentally fair trial (also guaranteed under the Fifth and Fourteenth Amendment Due Process clauses) is implicated if forced medication interferes with his trial. This is *procedural*, as opposed to *substantive*, Due Process. This right was a major concern of Justice Kennedy in his *Riggins* concurrence where he recognized that "elementary protections against state intrusion require the State ... to make a showing that there is no significant risk that the medication will impair or alter in any material way the defendant's capacity or willingness to react to the testimony at trial or to assist his counsel."[19] That issue was subsequently embraced by the majority as a key concern in *Sell.*[20]

3. Right to Counsel: When the medication's side-effects interfere with the defendant's assistance of counsel or even talking to counsel (*i.e.*, when it renders them a "zombie," sedates them, or makes them withdraw), then it impacts his Sixth Amendment (applied to state cases through the Fourteenth) right to assistance of counsel.[21]

4. Free Speech: In addition, and for the same reasons, if it prevents him from communicating, the First Amendment guarantee of "free speech" is implicated.[22]

5. State Constitutional Rights: Another vast and normally underused source of constitutional protections lies in state constitutions. For example, Washington (and many other states) actually have express constitutional Privacy clauses that have been interpreted to provide individual autonomy over medical treatment.[23] The Arizona Constitution guarantees criminal defendants the right to "Appear and Defend."[24] "Appear" connotes that not only can the defendant see the trial, but also the jury can see him. When the government tinkers with how he appears in a way that prejudices his defense, then that constitutional guarantee could be violated as well.

II. What triggers *Sell* litigation?

The seeds of a *Sell* hearing are sewn when the medical staff concludes that: 1) medication is necessary to restore to competency; 2) the patient has refused to take medication voluntarily; and 3) no alternative means of forcing the client to take medication exist.

A. When is medication necessary?

The central mandate of *Sell* is that intrusive medical intervention is a course of last resort. Competency restoration programs should consider lesser alternatives *before* asking to force-medicate. *See* § XIII.A, below, for greater discussion of alternative treatments.

B. What constitutes a "refusal" of treatment?

Because defendants are constitutionally entitled to refuse medication, it is not their *refusal*, but a *waiver* of that right of refusal, that must be clear and express. Even apparent agreement to medication may not constitute a knowing, voluntary waiver.

1. Is a defendant entitled to "informed consent?"

Yes. Whether a defendant waived his right to refuse medication

involves "informed consent." All medical patients are entitled to informed consent (information about potential negative side effects or outcomes) before making treatment decisions. If the defendant is not adequately informed about the possible negative consequences of medical treatment, then any consent is flawed. This principle should apply when medicating prisoners and pre-trial detainees as well.[25]

2. Does acquiescence to treatment waive the *Sell* issue?

Probably not. There is little case law on this issue. Acquiescence to medication has been held to mean consent in California.[26] However, that position may be challenged because waiver of *constitutional* rights must be by clear and express language.[27] Moreover, catatonic, terrified, retarded, or speech-impaired defendants may not be realistically capable of overt refusals. If the defendant is that impaired, mere acquiescence to treatment should not be equated with consent.[28]

3. Can someone else refuse medication for the defendant?

Yes. Some mentally ill clients are so incompetent that they accept medication when they should reject it. However, the criminal defense attorney should be wary of the potential ethical quandary of deciding what is in his client's best medical interests. Instead, an attorney should consider having a guardian or guardian *ad litem* appointed to make medical decisions for the defendant to avoid that dilemma. When the defendant is a juvenile, his parents retain the right to make medical decisions for him, and they can decide whether he should be medicated.

4. How do you discuss this decision with your client?

Defendants, especially when impaired, may not have the will or backbone to stand up to their doctors. Counsel can be helpful in asserting the refusal of medication for their clients. Furthermore, the defendant is entitled to legal advice when making this decision. However, restoration programs may not make communications with the attorney a priority. Indeed at Springfield, all inmate calls are tape-recorded, and doctors insisted on overseeing calls with counsel;[29] lawyers' demands for non-recorded and unobserved communications with clients were turned down. However, competency

restoration is a critical stage in a criminal prosecution where counsel is guaranteed.[30] Suggesting that doctors check with their counsel before denying a defendant confidential attorney calls usually corrects the situation; but if not, the court will provide an appropriate order.

5. Can a defendant discontinue medication he has agreed to take?

Yes. Deciding not to accept treatment, whether before it is given or after, is treated the same. Indeed, *Riggins* arose from a motion to *discontinue* antipsychotics.[31] If your client decides to stop treatment, you should send a firm letter invoking his right to cease treatment as soon as medically safe to the warden and chief psychiatrist at the restoration program.[32] You should also be entitled to an expert for a "second opinion" if your client is experiencing problematic effects from his treatment. In a case where a defendant was gaining a great deal of weight on second generation antipsychotics, his lawyer asked for an independent expert to evaluate whether the weight gain was drug-related, and if so, whether the defendant should demand to stop the medicine.

C. Can the government force-medicate your client without a *Sell* hearing?

Yes, but not if the medication is necessary solely to restore to competency. In *Sell*, the Supreme Court strongly suggested that the institution should pursue "alternative grounds" to forced medication before requesting a court to sanction forced medication solely for competency restoration.[33] Most commonly, the institution determines that the defendant poses an immediate danger to himself or others within that setting, and initiates so-called "*Harper*" hearings.[34]

In *Harper*, the defendant was incarcerated for a parole violation in a correctional facility designed to hold and treat seriously mentally ill offenders.[35] After he refused medication, the facility sought to medicate him involuntarily pursuant to their internal policy allowing it when the inmate suffers from a mental disorder *and* is either "gravely disabled"[36] or "poses a 'likelihood of serious harm' to himself, others, or their property."[37] Their regulations provided the inmate with some administrative and judicial process, including the rights to an administrative hearing in the facility, notice of the hearing and the reasons forced medication is being sought, call and confront

witnesses, assistance from a "lay advisor", and appeal the decision internally and to the state court.[38] The Supreme Court condoned force medicating Harper, holding that those internal administrative regulations comported with substantive and procedural due process.[39]

As a result, the federal government enacted C.F.R. 549.43, providing substantially similar procedures for administrative forced medication hearings in federal institutions.[40] Interestingly, however, the regulation appears more expansive, allowing the administrative officer (*i.e.*, psychiatrist) conducting that hearing to determine "whether treatment or psychotropic medication is necessary in order *to attempt to make the inmate competent for trial* or is necessary because the inmate is dangerous to self or others, is gravely disabled, or is unable to function in the open population of a mental health referral center or a regular prison."[41] Courts have been confused by seemingly different directives from the *Sell* Court (preference for exhausting alternative grounds for forced medication), and C.F.R. 549.43.

1. Administrative Hearing for Danger/Gravely Disabled: The government probably does not need to pursue a *Harper* hearing before initiating *Sell* litigation. Some federal courts have found that C.F.R. § 549.43 must be exhausted first;[42] however, different federal courts have held otherwise.[43] Although courts are divided, it should not be necessary to exhaust administrative remedies, particularly when treating clinicians have concluded that the defendant is neither dangerous nor gravely disabled.

Where courts have remanded a case seeking a *Sell* hearing for a *Harper* administrative hearing instead, they lament that the government had not followed the *Sell* Court's directive to pursue alternate grounds first.[44] However, *Sell* does not require that *Harper* hearings necessarily or automatically precede a *Sell* determination. To the contrary, it merely stated that, "a court asked to approve forced administration of drugs for purposes of rendering a defendant competent to stand trial, should ordinarily determine whether the Government seeks, or has first sought, permission for forced administration of drugs on these other *Harper*-type grounds; and, if not, why not."[45] To avoid a remand for an administrative hearing, ensure that the record clearly indicates that treating clinicians do not believe circumstances warrant a *Harper* hearing (*i.e*., the defendant is not gravely disabled and does

not present a danger to himself, others, or property). Doctors often include such information in their competency reports to the court. Enlist your client's treating clinicians' help in making the record clear on this issue.[46]

2. Administrative Hearing for Competency: *Sell* issues should not be addressed in the administrative context, not withstanding the language of the C.F.R. referring to involuntary medication for competency restoration. That provision was created in response to *Harper* (that pre-dated *Sell* by more than a decade), and dealt solely with force medicating a defendant because he was presently dangerous or gravely disabled.[47] Relying on that language and the "doctrine of exhaustion," the Fifth Circuit stated in *dicta* that an administrative hearing as to force-medicating the defendant for competency must precede a judicial *Sell* hearing for the same purpose.[48] However, it is unlikely elsewhere that restoration programs will have to conduct redundant administrative hearings before resorting to *Sell*. Moreover, *Sell* clearly contemplated *judicial* determinations of its factors, and distinguished legal questions about competency restoration from *Harper*'s purely medical question.[49] Hence,"[i]t is inappropriate for [clinicians at an institution] to determine whether or not prosecutorial interests are so significant that a medication order issued pursuant to *Sell* should be pursued."[50]

Even if the C.F.R. did require that administrative hearings precede judicial *Sell* hearings, the "doctrine of exhaustion" allows courts to bypass administrative procedures under "extraordinary circumstances."[51] Such conditions "typically arise when the administrative process would be inadequate or futile, the claimant challenges the legality of the administrative process itself, or the claimant has advanced a constitutional challenge that would remain after the completion of the administrative process."[52] *Sell* made it quite clear that, unlike *Harper* concerns, *Sell* addresses legal questions that cannot be resolved by medical professionals. Thus, administrative procedures do not come close to satisfying *Sell* requirements, nor provide the defendant with adequate procedural or substantive due process.[53]

3. Treatment Differences between *Harper* and *Sell*: In fact, the Supreme Court's suggestion that administrative *Harper* hearings would obviate the need for judicial *Sell* hearings may be overly simplistic. Medicating for competency and medicating for danger may be entirely different. According to respected forensic psychiatrist Dr. Jack Potts of

Phoenix, a doctor in a clinical setting may prescribe far less psychiatric drugs (to reduce the risks of side-effects) to help a floridly psychotic individual "feel better" than a doctor in a competency program to restore his competency. In the latter, exposure to more dangerous drugs may be justified due to the theory that competency only has to be maintained through trial and sentencing; once past that, the high dosage may be reduced or less problematic drugs substituted. Dr. Potts also pointed out that forced medication under *Harper* is short-term, usually only for a few days, and once the defendant's dangerousness passes, drugs are discontinued. Because restoring and maintaining competency requires long-term drug administration, *Harper* hearings cannot supplant *Sell* litigation. You may therefore be able to forego a *Harper* hearing by showing that the means and goals of administrative involuntary treatment significantly differ from those of *Sell*.

III. How is *Sell* litigation initiated?

Restoration doctors tell the prosecution that they believe the defendant should be medicated in order to restore him, but that he rejects that treatment. They will ask him to move for a court order allowing forced medication. Because it is the prosecution's burden of proof, they must initiate the litigation.

A. What court conducts the *Sell* hearing?

Sell litigation, at least in federal practice, is conducted in the jurisdiction where the case lies. It is part and parcel of the criminal case – as opposed to civil commitment procedures that generally occur in the jurisdiction where the defendant presently resides. In federal and many state jurisdictions, restoration programs are situated in another venue.[54] In federal cases, it is not clear whether the court will physically conduct the hearing in its own venue or go to the location where the defendant is for the *Sell* hearing. In some cases, the court and lawyers have traveled to the jurisdiction of the medical facility, borrowed a local federal courtroom, and held the hearing there.

B. Can commissioners or magistrate judges conduct *Sell* hearings?

Probably not, though they may take evidence and make recommendations for a higher judge to use to rule. Whether a *Sell* hearing is conducted by a junior judicial officer (like a magistrate judge or commissioner

who is an employee, as opposed to an appointed or elected judge) has been debated. In the Ninth Circuit, for instance, magistrate judges are not permitted to make *Sell* rulings.[55] Nonetheless, they may conduct hearings to establish facts, and then make recommendations to the assigned district court judge who would render the decision. In some state jurisdictions, similar lower judicial officers have conducted these hearings. Practitioners should nonetheless request that judges both hear the evidence and make the rulings: the findings of law and fact are complex, and most courts will want their independent judiciary to handle such complicated undertakings.

1. Was the judge tainted by judicial training?

On July 8, 2004, federal magistrate judges were provided with a training session called *Competency and Dangerousness Issues Presented to Magistrate Judges*, at the National Workshop for U.S. Magistrate Judges in Chicago. Springfield's Dr. Wolfson provided written materials and a lecture that he expressly hoped would be used later as a resource when the judges had to conduct *Sell* hearings.[56] His teachings unmistakably advocate the government's position favoring medicating incompetent defendants. You may want to consider asking judges whether they received any training on *Sell* hearings from persons representing restoration programs, as it could taint the judge.

C. Does *Sell* only apply pre-trial?

Yes, by its plain language, *Sell* applies pre-trial. The first prong of *Sell* refers to "the government's interests in bringing to trial."[57] The second prong balances that against the defendant's interests in avoiding drug side-effects that interfere with his ability "to assist counsel in conducting a trial defense."[58] Nonetheless, nothing in *Sell* excluded it from applying to post-trial litigation. Thus, the Fourth Circuit applied it to defendants pre-sentence.[59] Jurisdictions are split over whether it applies post-sentencing. *Sell* has been used in federal probation or supervised release violations in Delaware and West Virginia.[60] On the other hand, the Eighth Circuit held that the government may force medication on a defendant who was incompetent to be executed without resort to a *Sell* hearing; *certiorari* was denied by the Supreme Court in that case.[61]

IV. How do I prepare for the *Sell* hearing?

A. What discovery should I seek?

You should consider the treating clinicians as government "experts" and proceed accordingly. Obviously, it is important to secure their resumes, reports, transcripts of prior testimony, case law summarizing their testimony, and their publications. Make efforts to verify their stated credentials. Beyond that, you should demand a complete copy of your client's medical records at the restoration facility. In one case, a Springfield psychiatrist sought to administer drugs known to trigger diabetes. He testified at length about the care they took to ensure the defendant would not be at risk with these drugs, including checking family history. Because counsel had gotten their client's Springfield medical records, they could confront the doctor with his own intake forms reflecting a pervasive family history of diabetes – establishing instead Springfield's cavalier approach to treatment: prescribe now, ask questions later!

B. Do their doctors have to specify the drug regimen they recommend?

Yes. We have additionally seen government doctors refuse to commit on the medication they would use because they "wanted to involve the patient in all treatment decisions." In fact, the patient had made his treatment decision (no drugs), and they wanted to override it! Their purpose instead was to hinder the defense from preparing to challenge the drug choice in the *Sell* hearing. There is little law on point, but the Ninth Circuit recently recently required drug specification.[62] It reasoned that, otherwise, how else can the Court decide whether that treatment is efficacious and offers the least serious side-effects? In addition, a Nebraska District Court Judge recently remanded a *Sell* hearing to the magistrate judge for gathering more facts, specifying that the lower court needed to ascertain the type of medication being contemplated before a decision can be made on the *Sell* issue.[63]

C. What investigation should I do?

You should gather as much of your client's medical and psychological records as possible. Bear in mind that if he has been medicated with the proposed drug before, and it did not work, you should be able to foreclose using it again. You may

also uncover a medical condition or family history that counterindicates using a given drug.

D. Do I need to have an expert?

Most likely, yes. You probably will not need an expert if the only issue in your case is the legal determination whether important governmental interests are at stake. However, the other three prongs of *Sell* call for involved medical evidence that depends on expert testimony. Government doctors can become highly "invested" in their opinions, so they cannot be relied upon to testify favorably for the defense.

You can also bolster your doctor's expertise with similar expert opinions from other cases. Through resources like NACDL (or its mental health committee), its state affiliates, or the Federal Defender Organization, you may locate testimony or affidavits from other doctors backing your expert's conclusions.[64] These sworn opinions do not supplant having your own expert, but they do support him, and are less expensive than having a bevy of doctors testify.

E. Do I need to learn the science?

Yes. You *do* need to develop a fundamental understanding of the science. Government doctors may skirt it in their opinions, and you have to be ready to discredit glib theories with hard science. The authors have reviewed a number of failed *Sell* hearings where doctors just stood on their expertise that certain medications would be effective, and were not challenged with controverting research.

By understanding the neurochemistry of how the brain and certain drugs function, you can impeach their experts, showing that the proposed medicine does not correct the biological problem causing incompetency. For instance, antipsychotics are a misnomer, as they do not correct all types of psychoses. They block some of the brain chemical, dopamine, so are usually effective on psychoses caused by excess dopamine (*e.g.*, Schizophrenia, Dementia, and Mania).[65] But, psychoses that do not have excess dopamine (such as Delusional Disorder, severe Depression, or those caused by brain damage) may not improve with dopamine-blocking drugs. Moreover, a healthy amount of dopamine is necessary for proper brain functioning; so reducing it in someone with a normal amount of it, interferes with normal brain chemistry.

Government doctors with an agenda will tend to paint with an overly broad

brush, repeating the mantra of "because he is psychotic, we treat him with antipsychotics."[66] When you can counter such generalities with the neurochemistry of both the disease and the drug, then the judge can appreciate why the recommended drug is inappropriate for this defendant.

1. The Medical Model: To challenge doctors' opinions, you should understand how they come up with treatment recommendations. The "medical model" is a set of procedures physicians are trained to follow.

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1. *See United States v. Sell,* 539 U.S. 166, 169-70 (2003).

2. *Id.*

3. The authors recently gave a presentation on litigating forced medication cases at the 2007 NACDL Annual Conference in San Francisco. In preparation for that presentation, Doug Passon interviewed Dr. Sell.

4. *See, e.g.,* Carolyn Tuft, *Judge Rules No Sell Trial Next Week*, St. Louis Post Dispatch, Nov. 23, 2004, at C1. Although the tapes have never been made public, the expert in Dr. Sell's case (Dr. Robert Cloninger) was allowed to view them in connection with a subsequent competency evaluation. He filed a report with the court declaring that the inhumane treatment by Springfield staff had exacerbated competency issues. The newspaper reported the following exerpts from an affidavit submitted by Dr. Cloninger which contained harrowing descriptions of the abuse he witnessed on the video tapes:

> On Nov. 9, 1999, a team of seven guards – some wearing riot gear of heavily padded vests and black helmets with tinted face shields – pulled Sell from his jail cell. Sell cooperated "fully and is [sic] peacefully" in the move to an isolation cell "where his clothes are cut from his body, he is injected seemingly unnecessarily with a sedative and he is handcuffed to an item referred to as a 'black box.'" Sell was left on the concrete slab for 19 hours, Cloninger noted.
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> On Feb. 19, 2000, a guard is seen preparing a shower and taking Sell into it. Sell is in the shower, while a female staff member is seen

> "peering into the shower cell." "Abruptly, Dr. Sell is seen forcibly falling forward out of the shower cell room." The guard then pulls Sell, who is handcuffed behind his back, forward and onto the floor, Cloninger said. "As Dr. Sell lies [sic] in the floor naked except for his scanty underpants," the guard continues to "push or pull" Sell by his handcuffed wrists down the hall and back to his cell.
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> An internal investigation, Cloninger wrote, shows that the guard had been spraying Sell with scalding hot water while calling the female staffer to watch. Sell suffered cuts on his left hand, marks from the dragging on his back and first-degree burns on his legs, chest and back, Cloninger wrote.
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> "The water was sprayed forcefully onto Dr. Sell by a hose that had been pre-arranged by the (guard) even before escorting Dr. Sell to the shower," Cloninger wrote, noting that the water temperature was 120 degrees Fahrenheit.

Id.

5. Dr. Sell was represented by Lee Lawless (Federal Public Defender for the Eastern District of Missouri) and Barry Short (Lewis, Rice & Fingersh in St. Louis).

6. *Sell*, 539 U.S. at 169.

7. Dr. Cloninger is a professor of Psychiatry and Genetics at the Washington University School of Medicine in St. Louis. He is also the director of the Sansone Family Center for Well-Being.

8. *Sell*, 539 U.S. at 183 (citing *Washington v. Harper*, 494 U.S. 210, 221-23 (1990) and *Riggins v. Nevada*, 504 U.S. 127, 134-35 (1992)).

9. *Sell*, 539 U.S. at 180-81.

10. *Id*., 539 U.S. at 180.

11. *Riggins*, 504 U.S. at 130-31.

12. *Id.*, 504 U.S. at 135.

13. *Id.*, 504 U.S. at 133.

14. *Id.*, 504 U.S. at 138 *et seq.* Justice Kennedy acknowledged that:

> ... the defendant's behavior, manner, facial expressions, and emotional responses, or their absence, combine to make an overall impression on the trier of fact, an impression that can have a powerful influence on the outcome of trial. If the defendant takes the stand ... his demeanor can have a great bearing on his credibility, persuasiveness, and on the degree to which he evokes sympathy. The defendant's demeanor may also be relevant to his confrontation rights.
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> The side-effects of antipsychotic drugs may alter demeanor in a way that will prejudice all facets of the defense. Serious due process concerns are implicated when the State manipulates the evidence in this way.

Id., 504 U.S. at 142.

15. *Sell*, 539 U.S. at 179, 181-82.

16. *Id.*, 539 U.S. at 178-80 (recognizing the "liberty interest" in avoiding unwanted administration of drugs).

17. *See Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *Winston v. Lee*, 470 U.S. 753, 759 (1985); *Harper*, 494 U.S. at 221; *Albright v. Oliver*, 510 U.S. 266, 272 (1994).

18. *Riggins,* 504 U.S. at 133-34.

19. *Id.*, 504 U.S. at 141.

20. *Sell*, 539 U.S. at 179.

21. *Riggins*, 504 U.S. at 143; *Geders v. United States*, 425 U.S. 80, 88

(1976).

22. *Bee v. Greaves*, 744 F.2d 1387, 1393 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214 (1985).

23. Wash. Const., Art. 1, §7.

24. Ariz. Const., Art. 2, §24.

25. *Benson v. Terhune*, 304 F.3d 874 (9th Cir. 2002). Observing that the right to refuse treatment is useless without knowledge of the treatment, the Third Circuit held that convicted federal prisoners have the constitutional right to information about the proposed treatment to make a rational decision on medical options. *White v. Napoleon*, 897 F.2d 103, 113 (3rd Cir. 1990).

26. *See People v. Bradford*, 15 Cal.4th 1229, 65 Cal.Rptr.2d 145, 939 P.2d 259, 336-37 (1997), *cert. denied*, 523 U.S. 1118 (1998).

27. *Fuentes v. Shevin*, 407 U.S. 67, 96 (1972).

28. Note that in *People v. Clouse*, 859 P.2d 228, 234 (Colo.App. 1992), *cert. denied*, 2003 WL 21688713 (Co. 2003), the defendant acquiesced to police entry and questioning. The Court found that that constituted a valid Fourth Amendment waiver – because nothing indicated that he was uneducated, had failing memory, or was in "an impaired state."

29. *Accord, United States v.Thompson*, 2007 WL 2480066 at *3 (M.D.Fla. 2007).

30. *Sturgis v. Goldsmith*, 796 F.2d 1103, 1109 (9th Cir. 1986); *United States v. Collins*, 430 F.3d 1260, 1264 (10th Cir. 2005); *Appel v. Horn*, 250 F.3d 203, 215 (3rd Cir.2001); *United States v. Klat*, 156 F.3d 1258, 1262 (D.C. Cir. 1998), *aff'd*, 213 F.3d 697 (D.C. Cir. 2000); *United States v. Barfield*, 969 F.2d 1554, 1556 (4th Cir. 1992).

31. *Riggins*, 504 U.S. at 130-31.

32. A number of psychiatric drugs require a period of decreased usage in

order to safely wean the patient from treatment. For instance, a class of antidepressants called SSRI's should be tapered down; abrupt cessation of medication results in "SSRI Withdrawal Syndrome," including dizziness, shock-like sensations, anxiety, fatigue, headache, irritability, nausea, and tremors. K. Black, *et al*., *Selective Serotonin Reuptake Inhibitor Discontinuation Syndrome: Proposed Diagnostic Criteria*, 25 J. PSYCHIAT. NEUROSCI. 355-61 (2000).

33. *Sell*, 539 U.S. at 181-182; *see also United States v. Rivera-Guerrero ("Rivera-Guererro II")*, 426 F.3d 1130, 1137 (9th Cir. 2005) ("The Supreme Court clearly intends courts to explore other procedures, such as *Harper* hearings for dangerousness before considering involuntary medication orders under *Sell*.").

34. *See Harper*.

35. *Id.*, 494 U.S. at 215.

36. The involuntary commitment statute at issue in *Harper* defined "gravely disabled" as "a condition in which a person, as a result of a mental disorder: (a) [i]s in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety, or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such
care as is essential for his or her health or safety." *Id*., 494 U.S. at 215 n. 3.

37. *Id*.

38. *Id*. at 216.

39. *Id*. at 236.

40. 28 C.F.R. § 549.43.

41. 28 C.F.R. § 549.43 (a)(5)(emphasis supplied).

42. *United States v. White*, 431 F.3d 431 (5th Cir. 2005); *United States v. Milliken (Milliken I")*, 2006 WL 2945950 (M.D.Fla., 2007); *United States v. Gonzalez-Aguilar*, 446 F.Supp.2d 1099 (D.Ariz. 2006).

43. *United States v. Valenzuela-Puentes*, 479 F.3d 1220 (10th Cir. 2007); *United States v. Bradley*, 417 F.3d 1107, 1114 n. 13. (10th Cir. 2005); *United States v. McKnight*, 2007 WL 2021848 (W.D.N.C. 2007).

44. In *White*, the government pursued involuntary medication in the district court on both *Harper* and *Sell* grounds, without offering any reasons for failing to exhaust administrative procedures. The Court was concerned that the government did not first seek medication on "alternative grounds" as *Sell* suggests. *White*, 431 F.3d at 435.

In *Gonzales-Aguilar*, the judge criticized the Bureau of Prisons for not conducting a *Harper* hearing, despite "overwhelming evidence" that defendant met at least two of the *Harper* criteria ("gravely disabled and unable to live in an open population"). *Gonzales-Aguilar,* 446 F.Supp.2d at 1105-06. The judge was concerned that the Bureau felt it no longer had the authority to conduct *Harper* hearings in the wake of *Sell*. *Id*., 446 F.Supp.2d at 1105-07.

In the authors' experience, the Bureau routinely conducts *Harper* hearings when it believes they are warranted. However, it is not in favor of court-ordered administrative hearings when its clinicians have already determined an inmate is neither a danger nor gravely disabled.

45. *Sell*, 539 U.S. at 183.

46. In at least one case, it was the defendant who complained that he had not first been afforded a *Harper* hearing. *Milliken I*. However, it is difficult to imagine circumstances where it would be advantageous to the defendant to force the government to pursue such a hearing where he would have less legal protection, and the outcome may foreclose any chance of a judicial *Sell* determination. *But see* § II.C.3, below, arguing that the nature and amount of medication necessary to address dangerousness might be different than that needed to address competency.

47. *Harper*, 494 U.S. at 215; 57 Fed.Reg. 53820 (Nov. 12, 1992) (codified at 28 C.F.R. § 549.43)(legislative history explicitly stating that implementation of this regulation was a direct result of the *Harper* decision).

48. *White*, 431 F.3d at 434.

49. *See, e.g., Gonzalez-Aguilar*, 446 F.Supp.2d at 1105 ("[i]t is inappropriate for BOP to determine whether or not prosecutorial interests are so significant that a medication order issued pursuant to *Sell* should be pursued.")

50. *See id.*, 446 F.Supp.2d at 1105.

51. *See, e.g., White*, 431 F.3d at 434.

52. *Id*.

53. It is also the authors' experience that the Bureau of prisons does *not* believe it is authorized to conduct administrative *Sell* determinations, notwithstanding the language of the C.F.R. However, you may be hard-pressed to find a Bureau representative to state that on record.

54. In federal cases, an incompetent defendant is "committed" to the custody of the U.S. Attorney General for restoration. The Attorney General will transfer that defendant to prison medical centers at either Butner, North Carolina, Springfield, Missouri, or several other sites. State jurisdictions often have a central facility (perhaps a state hospital or county facility) used for restoration.

55. *United States v. Rivera-Guerrero ("Rivera-Guererro I")*, 377 F.3d 1064 (9th Cir. 2004).

56. The authors, Federal Public Defenders in Phoenix, were able to secure a copy of the handout and could share it with fellow practitioners upon request.

57. *Sell*, 539 U.S. at 180.

58. *Id.*, 539 U.S. at 181.

59. *United States v. Baldovinos*, 434 F.3d 233 (4th Cir.), *cert. denied*, 546 U.S. 1203 (2006).

60. *See United States v. Morris*, 2005 WL 348306 (D.Del. 2005)(unpublished); *United States v. Kourey*, 276 F.Supp.2d 580 (S.D.W.Va. 2003).

61. *Singleton v. Norris*, 319 F.3d 1018 (8th Cir.), *cert. denied*, 540 U.S. 832 (2003).

62. *Rivera-Guererro II*. Springfield's Dr. Sarrazin "played games" by refusing to forecast his drug choices, even though he must have had them in mind. The Ninth Circuit was frustrated by his testimony:

> When counsel asked the FMC doctors at the February 6th hearing which specific drugs would be used in the course of treatment, Dr. Sarrazin simply offered a list of the available drugs – including Alanzapin, Risperidone, Perazidone, Haloperidol and Phuphesedene – instead of identifying the specific drug or drugs that the FMC intended to administer. Dr. Sarrazin went on to confirm that he would not be able to say "at this point ... exactly what medication" would be used and that often, many medications may be attempted before finding one that is effective.

Id., 426 F.3d at 1139 n.5. The Ninth Circuit criticized his obfuscation as "a non-specific and unhelpful general listing of available medications by the FMC doctors." *Id.*, 426 F.3d at 1140.

63. *United States v. Dallas,* 461 F.Supp.2d 1093, 1100(D.Neb. 2006).

64. For instance, we found a transcript where a Butner doctor testified that antipsychotic drugs are usually ineffective on persons with Delusional Disorder, which was helpful in a *Sell* hearing on a Delusional defendant.

65. Notably, however, highly reliable scientific research has shown that they only work in about 75% of the Schizophrenia cases. J. Lieberman, *et*

al., *Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia,* 353 N. ENG. J. MED. 1209-1223 (2005)(referred to as the Clinical Antipsychotic Trials of Intervention Effectiveness, or "CATIE" Study).

66. *See, e.g.*, *Bradley*, 417 F.3d at 1111.