Involuntary Medication, Trial Competence, and Clinical Dilemmas: Implications of Sell v. United States for Psychological Practice

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The recent U.S. Supreme Court decision in Sell v. United States (2003) raises a number of challenging issues for mental health professionals regarding the involuntary medication of individuals who are incompetent to stand trial. The authors examine the Sell decision, other relevant legal decisions, and research findings on coercion and procedural justice, and discuss the implications for mental health professionals involved in the treatment and assessment (both clinical and forensic) of defendants who may be affected by Sell. The authors conclude by proposing recommendations for mental health professionals working with defendants in Sell contexts.

Keywords: competence to stand trial, involuntary medication, coercion, procedural justice

The recent decision by the U.S. Supreme Court in Sell v. United States (2003) raises a number of important and challenging issues for the practice of professional psychology. In holding that a defendant who is hospitalized as incompetent to stand trial may be involuntarily medicated under some circumstances but not others, the Court was clearly applying a balancing test. The Court weighed the defendant’s autonomy and right to be free from unwarranted treatment, particularly when such treatment is chemical and arguably more invasive than other forms of mental health treatment. On the other hand, the Court also considered the state’s interest in restoring an incompetent defendant to an improved level of functioning sufficient to permit disposition of criminal charges in a timely fashion.

Because the Court’s ruling came in a case in which a hospitalized defendant declined to take medication prescribed by his attending physician, the case should not have implications for hospitalized defendants who agree to take such medications. However, the distinction between the willing and unwilling is less clear than it might seem initially. Must the standard for informed consent be applied, or is it acceptable to use a lower standard, involving more limited capacities for understanding and reasoning? To what extent may a treatment team attempt to persuade an unwilling patient to take medication before such attempts move from professionally appropriate advice to ethically problematic coercion? These particular issues (informed consent and coercion) have been investigated in recent empirical research (Bennett et al., 1993; Gardner et al., 1993; Hoge et al., 1997; Litz et al., 1995; Monahan et al., 1995) and scholarship (Greer, O’Regan, & Traverso, 1996; Hiday, Swartz, Swanson, & Wagner, 1997; Thibaut & Walker, 1975; Wertheimer, 1993; Wexler, 1993; Winick, 1992), so it is much more feasible to present an informed analysis of these issues than it would have been a decade ago.

In this article, we review the holdings in two cases relevant to Sell: Washington v. Harper (1990) and Riggins v. Nevada (1992). We will also discuss the amicus brief filed by the American Psychological Association (APA) regarding Sell, and the Sell decision itself. We will structure our comments by analogizing to other forensic contexts in which the question of involuntary medication has been raised. We will conclude by summarizing the implications and limitations of the Sell decision for clinical practice in forensic contexts, and by offering recommendations for mental health professionals who provide treatment services in such settings.

Legal Context

Sell was not the first U.S. Supreme Court decision to address the issue of involuntary medication. In deciding Sell, the Supreme Court relied primarily on two prior decisions (Washington v. Harper, 1990; see also Riggins v. Nevada, 1992) that involved involuntary medication. The court used these decisions to help formulate the balancing test that was used in Sell.

In Washington v. Harper (1990, p. 226), the Supreme Court considered a state law authorizing the forced administration of antipsychotic medication to defendants who are “gravely disabled” or represent a “significant danger to themselves or others.” The court recognized that an individual has a “significant” constitutionally protected liberty interest in “avoiding the unwanted administration of antipsychotic drugs” (Washington v. Harper, 1990, p. 221), but also recognized that the state has a legitimate interest in administering antipsychotic medication to a prison inmate who is dangerous to himself or others. Mr. Harper was a prison inmate.
diagnosed with a mental disorder that medical professionals thought was likely to cause harm if not treated, and Harper was determined to be a danger to himself or others. Under these circumstances, the Court held, the state law authorizing forced antipsychotic medication was constitutionally acceptable as a legitimate medical interest in order to reduce Harper’s danger to himself or others.

In Riggins v. Nevada (1992), the U.S. Supreme Court again considered the issue of forced medication. Riggins was a defendant who was on trial for murder and robbery, and who was initially treated with antipsychotic medication (Mellaril) after adjudication as incompetent to stand trial. After his trial competence was restored, Riggins moved to suspend the administration of Mellaril until after his trial, arguing that (a) its use infringed on his liberty interests, (b) its effect on his demeanor and mental state during trial would deny him due process, and (c) he had the right to show jurors his unmedicated mental state when offering an insanity defense. At Riggins’ trial, he presented an insanity defense and testified, but was convicted and sentenced to death. In reversing the state court decision, the Supreme Court again held that an individual has a constitutionally protected liberty “interest in avoiding involuntary administration of antipsychotic drugs” (Riggins v. Nevada, 1992, pp. 134–135). The Court cited Washington v. Harper in repeating that the state can override this liberty interest if it shows that the treatment is medically appropriate (which includes considering less intrusive means) and essential for the safety of the defendant or for others. The Court also suggested that one overriding state interest, constitutionally permissible in principle, is forced medication to render a defendant competent to stand trial if disposition of charges cannot be obtained through less intrusive means. However, on the basis of the facts of Riggins v. Nevada, the Supreme Court reversed the trial court decision because of a failure to make a determination of the need for antipsychotic medication and its medical appropriateness (including reasonable alternatives), and because the lower court failed to address Riggins’ liberty interests. The Court did not directly consider whether the administration of antipsychotic medication would have denied Riggins the opportunity to show jurors his true mental condition at the sentencing hearing. However, Justice Kennedy, in a concurring opinion, emphasized that antipsychotic drugs could have side effects that would interfere with a defendant’s right to a fair trial by altering his “behavior and demeanor” so he might appear unsympathetic to a judge or jury (Riggins v. Nevada, 1992, p. 145).

APA Brief for Amicus Curiae

Following the Supreme Court’s granting certiorari in Sell, the APA submitted an amicus brief (APA, 2002). The brief submitted not in support of either party, is important in the present analysis because it proposes relevant considerations for the mental health practitioner that the Supreme Court considered (and cited) in deciding Sell. In this amicus brief, the APA argued that the state’s narrow interest in involuntarily medicating Sell to restore his competence to stand trial should be weighed against the broader interest of an individual’s autonomous decision to mental health treatment choices. More specifically, the APA argued that antipsychotic medication should not be forcibly administered to a criminal defendant to render him competent to stand trial unless the government first proves to the trial court that less intrusive, nonchemical treatments would be ineffective. The brief argues further that if alternative nondrug therapies are not effective in restoring a defendant’s trial competence, the court should then consider whether the proposed medication would have a substantial likelihood of success in restoring competence, and whether its effectiveness clearly outweighs the risk from side effects. In addition, the brief urges the Supreme Court to adopt the reasoning that once these two questions are answered and antipsychotic medication is administered, the trial court should further consider the effect of antipsychotic drugs on a defendant’s Fifth and Sixth Amendment rights to a fair trial. In doing so, the APA amicus brief argued that the government must show that the antipsychotic medication will not materially impair a defendant’s ability to present an effective defense.

Sell v. United States

In Sell, the Supreme Court was asked to determine whether the Constitution permits the government to administer antipsychotic drugs involuntarily to a mentally ill criminal defendant in order to render that defendant competent to stand trial, and whether doing so deprives him of his protected liberty interest without due process of law. The case involves Charles Sell, a former practicing dentist with a long history of mental illness. Dr. Sell was adjudicated incompetent to stand trial for fraud and attempted murder. He experienced paranoid delusions and displayed psychotic behavior, and was eventually diagnosed with delusional disorder. Although the staff at the U.S. Center for Medical Prisoners, where he was held, recommended that he take antipsychotic medication, he refused, and the medical staff sought permission to administer the medication involuntarily. In determining whether it was constitutionally permissible to involuntarily administer antipsychotic medication, the Supreme Court first examined the Washington v. Harper and Riggins v. Nevada holdings discussed earlier. The Court indicated that Washington v. Harper and Riggins v. Nevada, taken together, meant that the Constitution permits the government to administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial, but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking account of less intrusive alternatives, is significantly necessary to further important governmental trial-related interests (Sell v. United States, 2003, p. 2184).

Thus, the Court used a balancing test to consider the circumstances under which forced medication of a mentally ill prisoner is appropriate. In the context of the pretrial criminal defendant who is incompetent for trial, however, the Court went further. It held that the trial court should balance the following considerations: (a) The court must find important governmental interests at stake, and it must do so on a case-by-case basis; (b) the court must conclude that taking medication will significantly further those state interests; (c) the court must conclude that involuntary medication is necessary to further those interests and that any alternative, less-intrusive therapies are not likely to produce the same results; and (d) the court must conclude that administration of the drugs is medically appropriate, and in considering medical appropriateness should consider whether administration of the drugs is in the individual’s best medical interests in light of their condition (Sell v. United States, 2003, p. 2184).
v. United States, 2003). The Court emphasized that this test was solely to weigh the government interest of rendering the defendant competent to stand trial, and that the issue of forcing medication in order to render a defendant less dangerous to him- or herself or others is a separate governmental interest that can be addressed under Washington v. Harper criteria prior to considering trial competence. Justice Scalia, in his dissenting opinion, observed that one consequence of this decision is that it may allow defendants to take medication voluntarily until trial is underway and then abruptly refuse to take the medication, thereby disrupting the legal process. This possibility bears consideration by mental health and legal practitioners involved in this process.

Implications of Sell v. United States

What does the Sell decision mean to the mental health practitioner? In one sense, Sell encompasses only the issue of involuntary medicating when an incompetent-for-trial defendant refuses to take antipsychotic medication that has been prescribed. Nothing in Sell appears immediately relevant to voluntary compliance with prescribed medications. If a mentally ill defendant agrees to take the prescribed medication and the individual is considered competent to make that decision, there should be no legal dispute. Clinically, however, the reality may be more complex. Whether a patient is willing to take medication voluntarily, and the nature of that willingness, often depends on the circumstances. Research in the areas of coercion and procedural justice has demonstrated that the distinction between refusal and coerced agreement is far from clear.

Refusal and Coercion

Much of the research on coercion has focused on how individuals are committed to psychiatric hospitals. Although there are differences between involuntary admission to (and treatment in) civil psychiatric hospitals and related processes in jails or forensic settings, the contours of the debate are similar. Some researchers have emphasized a patient’s right to make autonomous decisions and be treated with respect (Monahan et al., 1995), whereas others have stressed the potential benefits of a certain degree of coercion, noting that “the absence of judicious coercion, patients will not receive needed care” (Appelbaum, 1985, p. 306). In Sell, the individual’s autonomous decision regarding mental health treatment choices was highly valued, to be overridden only if there were important governmental interests at stake. As part of balancing these two concerns, the court understood that receiving needed care was essential if the state’s interest was to override the individual’s autonomy. Research on coercion has delineated the complexity of these questions and provides a useful framework with which to consider the potential clinical implications of the Sell decision.

There is no single, consensual definition of coercion, but all studies of involuntary patient hospital admission have used a definition that includes the absence of patient freedom to refuse hospital admission (Monahan et al., 1995). The distinction between voluntary and involuntary is highly subjective and situationally dependent (Wertheimer, 1993). Patients’ perceptions of coercion are frequently different than those of others, such as family and hospital staff, involved in the hospital admission process (Hiday et al., 1997). Coercion can be applied in the form of positive influence (e.g., persuasion and inducement using rewards) or negative pressure, such as threat or force (Lidz et al., 1995). Patients who reported experiencing greater coercion in the form of negative pressures perceived more coercion than individuals who reported coercion through positive pressures (Lidz et al., 1995), suggesting a relationship between form of coercion and the patient’s perception of autonomy.

Procedural justice involves a patient’s perception that others are listening, treating him or her with respect, and recognizing and considering his or her opinions (Lidz et al., 1995). Studies of perceived coercion in psychiatric hospital admission suggest that several forms of persuasion can affect a patient’s subjective feeling of autonomy. Verbal persuasion has been reported to be the most common form of coercion; the clinical staff’s power also affects how patients interpreted persuasion (Lidz, Mulvey, Arnold, Bennett, & Kirsch, 1993). The approach to staff-patient interactions appears related to patients’ perceptions of procedural justice, so patients’ sense of being coerced could be lessened if staff considered such findings (Lidz et al., 1995). The perceived fairness of the coercion is also relevant to procedural justice; the perceived motivations of others, and whether they consider the patient’s views, are components of such fairness (Hiday et al., 1997). Thibaut and Walker (1975) distinguished between process control (the manner in which arguments are made and information is presented) and outcome control (control of who makes the final decision), and reported that the greatest perceived procedural fairness occurred when patients had process control and a third party, such as a judge, had outcome control. Within the framework of therapeutic jurisprudence, some scholars (Wexler, 1993; Winick, 1992) have related perceived coercion to legal advocacy. For instance, when an attorney zealously advocates for a client and the client feels the hearing is fair, the client’s subsequent motivation for treatment may be enhanced (Winick, 1992).

Several studies conducted by the MacArthur Research Network on Mental Health and Law found support for this notion (Bennett et al., 1993; Gardner et al., 1993; Hoge et al., 1997; Lidz et al., 1995; Monahan et al., 1995). These studies suggest that it is possible for patients not to feel coerced (even in situations such as civil commitment hearings, which have clear coercive components) if they (a) perceived the motivation of the actors involved to be benevolent, (b) were given a voice, and (c) were treated with dignity and respect (Greer et al., 1996). Individuals reported feeling less coercion when given the procedural justice mentioned above than others not afforded this procedural justice even when committed against their will. Further, there was a striking difference between the perceptions of civilly committed patients regarding the attorneys and judges involved (which was mixed) and their perceptions regarding the treating clinicians (which was strongly negative) (Greer et al., 1996). This difference appeared to stem from the patients’ perceptions that they were treated with dignity and respect by the legal professionals.

Thus, the research on coercion and procedural justice suggests that altering the nature of an act can affect the perceived coercion. Allowing the patient a voice, acknowledging the patient’s opinion, and using positive pressure are each associated with lower levels of perceived coercion. So although Sell stresses the legal importance of safeguarding an individual’s autonomy through freedom from unwanted medication, this research underscores the potential clinical importance and particular approaches to diminishing per-
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intrusive means of ensuring his competence, and that involuntary treatments, in turn, may affect patients’ decisions regarding (a) whether to take prescribed medication voluntarily, and (b) whether to participate in other aspects of treatment when medication is ad-

ministered involuntarily.

**Competence for Execution and Involuntary Medication**

It is useful to consider the parameters and balancing test that may apply in the context of a different form of legal competency (competence for execution) and the implications of this context for clinicians working with Sell-related defendants. The Supreme Court did not make this analogy in Sell, but clearly could have, given their reasoning about the application of a balancing test that considers the severity of the offense with which the defendant is charged. In *Singleton v. Norris* (2003), the Eighth Circuit Court of Appeals held that a mentally ill prisoner may be involuntarily administered antipsychotic medication to restore competence for execution. Charles Singleton was convicted and sentenced to death for murder and aggravated robbery. He had been diagnosed in prison with schizophrenia involving extensive paranoid delusions and hallucinations (including the belief that he had already been executed), and he was involuntarily treated with antipsychotic medication because a medication review panel found that he was a danger to himself. The psychotic symptoms subsided, and an execution date was set. Singleton’s lawyers argued that forced medication at that point was unconstitutional because it was no longer in his long-term medical interest, and that his execution should be stayed until involuntary medication was no longer required to maintain his competence. The Court, in a different balancing test, held that the defendant’s decision became defective at a point when the defendant preferred to take medication rather than live in an unmedicated, psychotic state, stating that he takes medication voluntarily because he does not like the symptoms he experiences without it; and (b) he suffered no sub-

stantial side effects. The court reasoned that treatment was neces-

sary to alleviate his psychotic symptoms, there were no less-

intrusive means of ensuring his competence, and that involuntary medication in this case was medically appropriate. The dissent argued that state’s true motivation for forcibly administering med-

ication is called into question when an execution date has been set, as the “best medical interest” rationale is weakened considerably. The *Singleton v. Norris* decision underscores some difficult ethical issues in this context.

**Ethical Considerations**

Heilbrun, Radelet, and Dvoskin (1992) discussed the ethical issues associated with the potential treatment of an individual who is incompetent for execution, outlining arguments for and against treating such individuals. These considerations are particularly salient in light of the *Singleton v. Norris* ruling, and may gener-

alize as well to the Sell context. Arguments against providing mental health treatment to those incompetent for execution were summarized as follows: (a) the need to avoid harming those treated, (b) the risk that disclosures in therapy will be used for assessment purposes, (c) the need for paternalism when sufficient harm is possible, (d) the potential adverse impact on the clinician, (e) the potential undermining of patient and public perceptions of mental health professionals, and (f) the poor allocation of limited resources. They also summarized several arguments favoring such treatment: (a) respect for the wishes of the prisoner (if competent consent can be obtained, any refusal to treat would be substitution of the clinician’s values for those of the prisoner); (b) the need to clarify the issues underlying the refusal to treat (the goal of the state to restore competence, and the distinction between facilitating the death penalty vs. facilitating adjudication of other criminal charges); (c) the low risk of harm (in the sense that the death sentence would be facilitated) from some forms of treatment (such as psychotherapy and psychosocial rehabilitation), as contrasted with the higher risk of harm from other treatment such as psychotropic medication; and (d) the adverse impact on the milieu stemming from the failure to treat, such that not treating one individual could damage the treatment prospects for others. Hei-

brun at al. concluded that a mental health professional’s decision about whether to participate in treatment under the circumstances should depend on the nature of the treatment provided, the goals of treatment, the standard for competency (for execution), and a determination of the prisoner’s ability and willingness to consent to treatment. Furthermore, the importance of the patient’s consent should vary according to the treatment being considered. The link between the nature of the intervention (antipsychotic medication vs. psychotherapy/psychosocial rehabilitation) and the potential for immediate improvement in competence-related symptoms is particularly relevant. The authors suggested that there is an ethical demand for mental health professionals to abstain from the invol-

untary treatment of a defendant who is incompetent for execution in cases when treatment is likely to directly and immediately improve competency-related deficits, but less demand for abstan-

ing from other forms of treatment that are helpful but less directly targeted to competency-relevant deficits. This approach incorpo-

rated a balancing test comparable to what the Court applied in Sell and *Singleton v. Norris*: the state’s interest against an individual’s autonomy, and the individual’s therapeutic interests against the potential medical and legal harm stemming from involuntary treat-

ment to restore competency.

**Sell: Implications for Clinical Practice**

*Sell* has a number of implications for the assessment and treat-

ment of defendants who are incompetent to stand trial. We will review these implications in this section and, following a discuss-

ion of the limits of the *Sell* decision, propose a set of recommenda-

tions for psychological practice in light of *Sell*.

Dr. Sell was a defendant who declined to take prescribed psy-

chotropic medication during his hospitalization as incompetent to stand trial. The Court seemed to assume that Sell was competent to consent to treatment (and therefore comparably competent to
refuse it). Further, the Court implicitly indicated that Sell should be considered nondangerous, in that he did not present an imminent threat of harm to others or to himself during his hospitalization. This suggests that the constructs of voluntariness, competence to consent to treatment, and dangerousness will be important for policymakers, clinical administrators, and clinicians to consider in determining whether a given patient falls under the auspices of Sell. Because they are so important, it follows that their measurement will need to be careful and formalized.

It is also clear that the Sell decision, and the changes in jurisdictional law that will follow, will each underscore the importance of the working relationship between treatment teams and defendants who are hospitalized as incompetent to stand trial. Some defendants might express unwillingness to take medication, even when the attending psychiatrist prescribes it and the treatment team recommends it. Treatment team members can help such patients to consider the advantages and disadvantages of declining to take medication. When such efforts incorporate (in procedural justice terms) positive persuasion, they are less likely to be perceived by the patient as coercive and perhaps more likely to result in a change in the patient’s unwillingness to take medication. However, when persuasion is negative (when the patient does not perceive that he or she has a voice and an opinion that is being considered, and when the message appears threatening), many patients will be less likely to change their unwillingness to take such medication.1

Next, Sell highlights the importance of nonmedical treatment strategies for defendants who are incompetent to stand trial. There will always be patients who, for a variety of reasons, decline to take psychotropic medication. Such patients may not decline other forms of treatment, however, so programs should develop and strengthen nonchemical interventions that are more likely to yield improvement in trial-competence-relevant deficits such as communication, information retention, and reasoning. When such interventions are based broadly on psychosocial rehabilitation approaches (Lieberman et al., 1986, 1993, 1998; Wallace, Liberman, MacKain, Blackwell, & Eckman, 1992) and more specifically on relevant skills (Grasso, 1992; Siegel & Elwork, 1990), they may work to improve deficits in some patients who might not have responded favorably to psychotropic medication. Such interventions are delivered for another reason as well; it is important to document that reasonable and systematic efforts have been made by the hospital to treat trial-competence-relevant deficits, so if an opinion is offered that a patient is not restorable to trial competence, it can be offered in light of these unsuccessful efforts.

It is important to consider formally the response style of patients meeting Sell criteria and declining medication.2 Such response style may be (a) reliable or honest (a genuine attempt is made to be accurate; factual inaccuracies result from poor understanding or misperception); (b) malingering (conscious fabrication or gross exaggeration of psychological or physical symptoms, understandable in light of the individual’s circumstances and not attributable merely to the desire to assume the patient role, as in factitious disorder); (c) defensive (conscious denial or gross minimization of psychological or physical symptoms, as distinguished from ego defenses, which involve intrapsychic processes that distort perception); and (d) irrelevant (failure to become engaged in the evaluation; responses are not necessarily relevant to questions and may be random; Rogers, 1984, 1997). The implications for assessment and treatment may differ for those who are not accurately reporting their own symptoms and experiences to treatment teams. For example, a defendant might malinger auditory hallucinations and delusions as part of an attempt to avoid prosecution for a nonviolent offense that would nonetheless (perhaps because of his criminal conviction history) result in a very long prison sentence if he or she were convicted. If the patient’s response style is other than reliable, treatment teams must rely more on testing and collateral observations, and less on self-report, in gauging response to any kind of intervention.

Under Jackson v. Indiana (1972), defendants who are incompetent for trial cannot be hospitalized indefinitely. Sell complicates Jackson v. Indiana proceedings somewhat with the prospect of a defendant who might be restorable to competence through treatment with psychotropic medication declining to take such medication. Would such a defendant be considered unrestorable under Jackson v. Indiana? This presents a potential dilemma for both courts and forensic clinicians, but there are several important considerations for the latter. The relationship between a defendant and his or her attorney is a component of trial competence that is sometimes overlooked, but an attorney who is inclined to work with a client with some remaining deficits to resolve charges may create a lower demand for a client’s capacities for understanding and assisting than an attorney who maintains that the client must be able to function more autonomously as a defendant. Next, it may become important to consider a defendant’s capacities broadly and formally, using a measure that has been developed and validated for that purpose, to put into perspective the impact of specific symptoms (e.g., delusions) on these broader capacities. It is also important to consider whether the defendant wishes to (or would consider) pleading guilty (Bonnie, 1992), as the contextual demands for disposing of charges through a plea bargain differ somewhat from those involved in a trial. Finally, it is useful to consider what impact psychotropic medication might have had on trial-competence-relevant deficits. This can be gauged in two ways: through the individual’s history of response to medication, and through scientific data on the efficacy of specific medications with individuals with similar diagnoses.

Limits of Sell

Apparently neither Sell nor Singleton v. Norris applies to circumstances under which an incompetent defendant voluntarily agrees to take psychotropic medication. However, as the research on coercion and procedural justice demonstrates, gauging when

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1 We are not aware of any scientific evidence regarding the effectiveness of these two forms of coercion (positive and negative) on whether patients actually take prescribed medication under such circumstances.

2 Although forensic clinicians should always consider the possibility that a patient is responding in a way that is deliberately inaccurate, a formal and intensive analysis of response style is often unnecessary when there is reasonable consistency between a patient’s self-report, behavior, and history obtained from multiple sources. In Sell-related cases, however, it seems prudent to conduct a formal analysis of response style for all patients refusing medication under these circumstances, with the expectation that defensiveness, rather than malingering, will be the more frequently observed problem.
such a decision is voluntary is difficult. The facts of Sell do not suggest that Dr. Sell was incompetent to consent to treatment. But what of the defendant who may be incompetent to consent to treatment as well as incompetent to stand trial? The APA amicus brief (APA, 2002) makes the distinction between an individual such as Dr. Sell, who was diagnosed with delusional disorder, and individuals with other psychotic disorders who may be incompetent to stand trial and incompetent to make treatment decisions. The Court further notes that involuntary medical treatment occurring when an individual is incompetent to make treatment decisions is typically a civil matter. In those cases, the research on coercion is particularly important, as a psychotic individual who agrees to take medication may not have been competent to consent to treatment. Thus, mental health professionals and legal professionals should pay careful attention to issues of procedural justice, because the implications may not only affect an individual’s mental health treatment, but in certain contexts may also affect the outcome of subsequent legal decisions.

Another limit of Sell involves its focus on defendants who are not demonstrably dangerous to self or others. The Supreme Court assumed that Dr. Sell was not a danger to himself or others; however, if a trial court finds that a mentally ill inmate does present such a danger, then institutional policy regarding emergency treatment orders (flowing from considerations set forth in Washington v. Harper) would supersede the need for a Sell balancing test on the issue of involuntary medication. Such a balancing test would only be needed, then, with defendants who are nondangerous and competent to consent to treatment.

Proposed Recommendations for Mental Health Professionals

Sell presents a complex and challenging set of considerations for mental health professionals who are involved in assessing and treating defendants who are incompetent to stand trial. In light of the discussion in this article, we propose the following recommendations to assist psychologists and other mental health professionals who are working with such defendants.

1. **Consider the patient’s willingness to take prescribed medication.** Patients who take psychotropic medication as prescribed are not among those affected by Sell.

2. **Formally measure competence to consent to treatment in patients who decline to take prescribed psychotropic medication.** Patients may have a variety of reasons for declining to take psychotropic medication, ranging from the rational (e.g., the associated tardive dyskinesia outweighs the benefits from primary symptom reduction) to the misinformed but understandable (e.g., medicine is poison) to the clearly irrational (e.g., the medicine reduces Godlike divinity). When competence to consent to treatment is formally measured, using a tool such as the MacArthur Competence Assessment Tool-Treatment (MacCAT-T; Grisso & Appelbaum, 1998) and a targeted interview focusing on the nature of the information being considered and the reasoning process yielding the final decision, then the treatment team can determine whether it would be appropriate to request a guardian advocate (or the jurisdictional equivalent) to make a substituted judgment regarding treatment. Such use of the MacCAT-T would require some care, as it was developed to help the evaluator gauge an individual’s understanding of the risks and benefits of treatment. However, there is sufficient flexibility within the “Generating Consequences” section of the tool to expand “What are some ways that these (benefits and risks or discomforts) might influence your everyday activities at home or at work?” to encompass a treatment’s potential impact on functional legal capacities. In a detailed interview accompanying administration of the MacCAT-T, the clinician could explore the individual’s understanding of and reasoning about treatment in the particular context of legal competence. This would involve obtaining information regarding the individual’s perceptions regarding the risks and benefits of regaining trial competence, which could then be used to assess the rationality exercised in the decision about receiving treatment designed to help restore the defendant to competence to stand trial.

3. **Analyze the prescribed medication regimen carefully for potential efficacy in addressing clinical symptoms and functional legal capacities, including the impact of side effects on the individual’s functioning.** In many cases, the potentially favorable impact of the appropriate kind and dosage of psychotropic medication on clinical symptoms and functional capacities is clear. In certain other cases, however, the expected improvement in such areas may be more limited. In yet others, improvements may be offset by significant medication side effects, particularly those involving involuntary motor movements. When the potential advantages of medication are negligible or outweighed by disadvantages, treating clinicians may decide that prescribed psychotropic medication need not be part of the larger treatment plan.

4. **Consider “dangerousness” according to immediate risk of harm to self or others among patients who decline to take prescribed psychotropic medication.** It is apparent that patients who meet the criteria for an emergency treatment order stemming from their imminent risk of harm toward self or others are also not among the patient cohort envisioned by the Court in Sell. Thus, patients who are incompetent to stand trial and appear imminently suicidal or likely to harm another patient or a staff member could be administered psychotropic medication, if appropriate and prescribed, involuntarily if necessary.

5. **Emphasize the value of the working relationship between the treatment team and the patient.** The identification of common goals and the implementation of interventions to address them, when taken seriously in the treatment-planning process, should reduce the tendency of some patients to decline prescribed medication because they are angry, frustrated, confused, or attempting to assert self control in one of the few possible ways on a forensic inpatient unit. But there is a common goal that is shared by hospital...
administrators, treatment teams, and many patients who are incompetent to stand trial: alleviation of competence-relevant deficits that keep the individual hospitalized. If this goal is clearly identified as important and shared, then psychotropic medication becomes a means of helping to achieve that goal. However, if medication has become the basis for disagreement among treatment team members—if some on the treatment team are encouraging medication compliance, whereas others are less clear about such encouragement—then the refusal of some patients to take prescribed medication may reflect treatment-team dissonance as well as more personal reasons.

6. Use persuasion in attempting to change the medication refusal of patients who are competent-to-consent and nondangerous. In this article, we have discussed some of the characteristics of procedural justice: listening, treating patients with respect, and recognizing and considering their opinions. Individuals who are subject to this kind of influence report feeling more autonomous, and less coerced, than those who feel forced or threatened. When treatment team members are willing to listen respectfully to a patient declining medication, identify rational impediments (e.g., side effects) to medication compliance, and be somewhat flexible in resolving the problem, then some patients who decline such medication may change their minds.

7. Avoid using negative coercion with these individuals. With Sell, it is clear that negative coercion (threats or force) cannot legally be applied to defendants who are competent to consent to treatment, nondangerous, charged with less serious offenses, and who decline to take prescribed medication. In this respect, the law is now consistent with professional ethics, which would certainly bar this approach to promoting treatment compliance unless there is an immediate, compelling justification (such as imminent danger to self or others) for involuntary medication.

8. Develop nonmedical intervention strategies to address deficits relevant to competence to stand trial. Psychosocial rehabilitation, using skills-based training, has demonstrated considerable success in improving deficits that may keep those with serious mental illness from living in the community (Liberman et al., 1986, 1993, 1998; Wallace et al., 1992). Targeted skills-based interventions also show some promise in improving deficits relevant to competence to stand trial (Grisso, 1992; Siegel & Elwork, 1990). For those forensic treatment programs that have not developed such interventions, Sell may function as justification to do so. Such skills-based, nonmedical interventions (which are more typically used to complement rather than replace medication) are particularly useful in the Sell context for two reasons. First, they may succeed in improving deficits in some patients to the extent that the evaluator might recommend that the patient has regained trial competence. Second, they allow the treatment team to document the delivery of a relevant and potentially useful intervention; if this intervention does not facilitate the improvement of competence-relevant deficits, this is helpful to consider regarding the question of whether the defendant can be restored to trial competence within the foreseeable future.

9. Formally measure response style in nondangerous, competent-to-consent patients who decline to take prescribed psychotropic medication. When staff members have reason to suspect that a patient’s motivation for declining prescribed medication is influenced by a conscious desire to avoid returning to court for disposition of charges, then it may be useful to emphasize other sources of information (records, third party interviews, formal testing of response style) in the description of that individual’s symptoms and response likelihood.

10. Describe results from these interventions in forensic assessment. This article has emphasized two points of importance in the forensic assessment of trial competence. First, it notes that the present law presents significant conceptual and applied challenges for mental health professionals working with criminal defendants. Consideration of the legal pre-
cidents and the applicable research on coercion, as well as the recommendations described in this section, should make these challenges less daunting.

References


Singleton v. Norris, 319 F.3d 1018 (8th Cir. 2003).


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