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Susan A. McMahon
*Georgetown University Law Center*, sam56@law.georgetown.edu

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# IT DOESN'T PASS THE *SELL* TEST: FOCUSING ON "THE FACTS OF THE INDIVIDUAL CASE" IN INVOLUNTARY MEDICATION INQUIRIES

Susan A. McMahon*

In November 2002, Herbert J. Evans, a 74-year-old with a long history of paranoid schizophrenia, walked into a United States Department of Agriculture Service Center in Wytheville, Virginia, to complain about a past due notice on his USDA loan.[1] Evans quickly became angry and, after ranting about the United States' descent into Communism, told the USDA employee that he had lived his life and "would not 'mind taking a few with me.'"[2] Evans was arrested and charged with forcibly assaulting, intimidating and interfering with an employee of the United States while the employee was engaged in her official duties.[3] After his arrest and a mental evaluation, the court determined he was incompetent to stand trial.[4] The only hope for restoring him to competency was the administration of antipsychotic medications, which Evans refused.[5] The government moved to have him medicated against his will.[6]

Thus began Evans' long and circuitous route through the criminal justice system. For the next four years, Evans was held at a prison medical facility while his case proceeded through several district court hearings and two appeals. During his time of confinement, he allegedly threatened to kill the federal judge hearing his case and was charged with that additional crime.[7] At some point, the courts decided the government interest in prosecuting Evans for these crimes was "important" because the crimes with which he was charged were "serious."[8] At no point did the courts consider whether Evans' lengthy history of mental illness or the fact that his crime was likely intimately intertwined with this illness undermined this government interest.

Criminal defendants who are incompetent to stand trial have a significant liberty interest in refusing the antipsychotic medication that could restore their compe-

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1. United States v. Evans, 293 F. Supp. 2d 668, 669–70 (W.D. Va. 2003).
2. *Id.*
3. *Id.* at 670.
4. *Id.*
5. *Id.*
6. *Id.*
7. United States v. Evans, No. 102CR00136, 2004 WL 533473, at *1 (W.D. Va. Mar. 18, 2004).
8. United States v. Evans, 404 F.3d 227, 238 (4th Cir. 2005).

tency. Intrusion upon that right is "a deprivation of liberty in the most literal and fundamental sense."[9] However, as with all constitutional rights, an individual's interest in making autonomous decisions concerning medical treatment can be outweighed when important government interests are at stake. In *Washington v. Harper*, the Supreme Court held the government interest in medicating inmates who pose a danger to themselves or others was sufficiently important to overcome a prisoner's right to refuse the medication.[10] *Riggins v. Nevada* applied the same reasoning to criminal defendants. Even though they had not been convicted of any crime, as the inmates in *Harper* had, defendants in pretrial detention could be medicated against their will when they posed a danger to themselves or others.[11]

*Sell v. United States* applied the *Harper* and *Riggins* reasoning well beyond the context of dangerous individuals. In *Sell*, the Court held that an incompetent, non-dangerous defendant could be medicated for the sole purpose of bringing him to trial.[12] To do so, the government must show: (1) important government interests are at stake; (2) involuntary medication will significantly further those interests; (3) involuntary medication is necessary to further those interests; and (4) the administration of the drugs is medically appropriate.[13] These factors, drawn from *Harper* and *Riggins*, require courts to evaluate the potential side effects of a proposed drug, the likelihood of restoration to competency with the medication, the availability of any alternate courses of action, the seriousness of the charged crime, and the special circumstances of the individual case.[14]

Given these criteria, the Supreme Court cautioned that instances where a defendant was medicated solely for the purpose of prosecuting him "may be rare."[15] However, that has not turned out to be the case. Since *Sell*, lower courts have approved the involuntary medication of incompetent defendants in over sixty-three percent of cases, including many cases in which the defendant was charged with a crime involving no physical damage to people or property or a crime that was indisputably a manifestation of the individual's mental illness.[16] The involuntary medication of non-dangerous defendants, predicted to be a "rare" occurrence, has instead become routine.

The problem rests with the structure of the test, consisting of four separate threshold factors, and its tilt in favor of the government. For example, with the

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9. Washington v. Harper, 494 U.S. 210, 237–38 (1990) (Stevens, J., dissenting) (arguing that the Court undervalued the respondent's liberty interest).

10. *Id.* at 227.

11. *See* Riggins v. Nevada, 504 U.S. 127, 135 (1992) (holding defendant should not have been administered antipsychotic drugs during the course of trial without finding there were no less intrusive alternatives, the medication was medically necessary, and it was essential for the sake of the defendant's safety or safety of others).

12. Sell v. United States, 539 U.S. 166, 179 (2003).

13. *Id.* at 180–81.

14. *Id.* at 179–81.

15. *Id.* at 180.

16. *See infra* Part III.

government interest factor, a court's only task is to decide whether this interest is important. If it is, that box on the four-factor list is checked. The court does not then balance that government interest against the defendant's countervailing interest in refusing medication. The use of a checklist comprised of threshold factors favors the issuance of involuntary medication orders because the court need not consider the defendant's interest in avoiding what the government seeks to do, "which necessarily involves physically restraining defendant so that she can be injected with mind-altering drugs."[17]

Moreover, the final three boxes on the checklist, which compel the court to answer medical questions about the efficacy of the antipsychotics and the risk of side effects, will be met in the vast majority of cases. The medical community has concluded that antipsychotic medication is the "gold standard" for patients with psychotic symptoms, and statistical studies have shown the medication works and side effects can be managed.[18] Barring unusual circumstances, these three boxes will be checked.

Therefore, the first factor—whether the government interest at stake is important—is often the only barrier between a defendant and involuntary medication. To show that a government interest is important, the government must prove the alleged crime is "serious."[19] Federal courts have found alleged crimes ranging from illegal reentry to credit card fraud to qualify as serious.[20] It is the rare federal crime that falls outside this category.

Yet the seriousness of the crime is not the only criterion. A court must also consider "the facts of the individual case" when evaluating the importance of the interest.[21] For example, the government may have less of an interest in prosecuting a defendant who has already been confined for a significant amount of time or likely will be confined to an institution for the mentally ill.[22] Some courts have also looked to the nature of the crime, whether violent or nonviolent,[23] as well as the government's likelihood of success on the underlying criminal charge[24] when

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17. *See* United States v. Lindauer, 448 F. Supp. 2d 558, 567 (S.D.N.Y. 2006).

18. *See, e.g.*, United States v. Diaz, 630 F.3d 1314, 1324–26 (11th Cir. 2011) (ordering involuntary medication and crediting testimony of Dr. Robert Sarrazin, who said antipsychotic medication was the "gold standard" for treating patients with schizophrenia and studies showed an 87% chance of restoration to competency).

19. Sell v. United States, 539 U.S. 166, 180 (2003).

20. *See, e.g.*, United States v. White, 620 F.3d 401, 410 (4th Cir. 2010) (finding credit card fraud to be a serious crime because defendant was charged with crimes that involve a maximum statutory penalty of over ten years); United States v. Sanchez-Cruz, No. EP-07-CR-144-DB, 2007 WL 4190692, at *1 (W.D. Tex. Nov. 19, 2007) (finding illegal reentry to be a serious crime because of the penalty defendant would face if convicted).

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

22. *Id.*

23. *See White*, 620 F.3d at 419–21 (holding forcible medication was not permissible, in part because the charged crimes were entirely nonviolent).

24. *See* United States v. Lindauer, 448 F. Supp. 2d 558, 571–72 (S.D.N.Y. 2006) (noting the indictment charged defendant with a crime—conspiring to act or acting as an unregistered agent of the government of Iraq—which she could not have committed without influencing normal people, and even lay people recognized she was seriously disturbed).

assessing the government interest.

The "facts of the individual case" analysis therefore provides an opportunity for the defendant to push the importance of the government interest below the threshold for satisfying the first factor of the *Sell* test. If warranted by the individual circumstances, the defendant can erase the checkmark usually placed there by default because he committed a "serious" crime. However, this consideration has largely gone unrecognized in the lower courts. Courts have instead become mired in discussions about drug dosages, treatment plans, and side effects. Because resolving these questions of medication specifics usually results in a finding that the drugs will be effective in restoring the defendant to competency with few severe side effects, the medication of incompetent criminal defendants has become commonplace.

In this Article, I explore the contours of the overmedication problem and offer as the solution a more robust assessment of the facts of the individual case under the government interest factor. Part I summarizes in broad strokes the medical and legal background of involuntary administration of antipsychotic medication, including the current state of medical knowledge about the treatment of psychotic disorders and the Supreme Court's series of decisions on involuntary medication of inmates and defendants. These decisions led to *Sell v. United States*, the controlling authority on the involuntary medication of defendants for the purpose of standing trial, which I analyze in Part II. Part III demonstrates the medication of defendants often takes place despite looming questions about the strength of the government's interest in prosecuting the defendant, due to the structure of the legal test and the misunderstandings surrounding the important government interest factor. Part IV proposes placing a new emphasis on this factor and its individualized assessments to identify those exceptional cases where involuntary medication is warranted.

## I. MEDICAL AND LEGAL FRAMEWORK FOR INVOLUNTARY MEDICATION

### *A. Medical Background*

Patients deemed incompetent to stand trial suffer from a wide array of mental illnesses, many of which are classified as "psychotic disorders."[25] Mental illnesses that fall into this category include schizophrenia, brief psychotic disorder, and delusional disorder.[26] Studies have shown that medications can successfully control the psychotic symptoms of many of the disorders in this category.[27] These

25. The Diagnostic and Statistical Manual of Mental Disorders groups disorders with prominent psychotic symptoms as "Schizophrenia Spectrum and Other Psychotic Disorders." AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 87 (5th ed. 2013) [hereinafter DSM-V].

26. *Id.* at 88–89.

27. ROBERT M. JULIEN ET AL., A PRIMER OF DRUG ACTION 95 (12th ed. 2011); *see also* Douglas Mossman, *Unbuckling the "Chemical Straitjacket": The Legal Significance of Recent Advances in the Pharmacological*

medications can be generally categorized into two groups—the first-generation typical antipsychotics and the second-generation atypical antipsychotics—and, while their efficacy rates are generally the same, their side effect profiles differ significantly.[28] Whether a defendant is involuntarily medicated with a typical or atypical antipsychotic usually depends on the availability of injectable forms of the medication, the defendant's past experiences with particular medicines, and the treating psychiatrist's personal preferences.[29]

*1. Psychotic Disorders*

The constellation of disorders considered "psychotic" includes symptoms such as delusions, hallucinations, catatonic behavior, disorganized speech, and negative symptoms, such as diminished emotional expression.[30] The specific diagnosis depends on which combination of symptoms a patient presents and how long a patient has had active symptoms.[31] With schizophrenia, for example, the patient must show some signs of the disturbance, resulting in impaired occupational or social functioning, for six months or more.[32] In addition, for at least one of those six months, the patient must present with one or more of the following symptoms: delusions, hallucinations, or disorganized speech.[33] Patients with delusional disorder, another illness characterized by psychotic symptoms, suffer from delusions, unaccompanied by any of the other above symptoms, for at least one month.[34]

While many disorders fall within the spectrum of psychotic disorders, schizophrenia is the most common and most studied.[35] Schizophrenics generally suffer from two different kinds of symptoms: positive symptoms and negative symptoms. Positive symptoms, which reflect an excess or distortion of normal functions,

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*Treatment of Psychosis*, 39 SAN DIEGO L. REV. 1033, 1048 (2002) ("[S]cientific evidence ha[s] shown overwhelmingly that schizophrenia was a brain-based illness that could be addressed effectively, though not cured, with pharmacological agents . . . .").

28. JULIEN ET AL., *supra* note 27, at 95–97; *see also* Brief for the American Psychiatric Ass'n as Amici Curiae Supporting Respondents, Sell v. United States, 539 U.S. 166 (2003) (No. 02-5664), 2003 WL 176630, at *15–19.

29. *See, e.g.*, United States v. Steward, No. 06-864-MRH, 2009 WL 4839529, at *2–3 (C.D. Cal. Dec. 14, 2009) (citing medical report recommending injections of Prolixin, a first-generation drug, which can be delivered in long-acting injectable form, reducing compliance issues); United States v. Mesfun, No. 05-858(WHW), 2009 WL 1704308, at *4 (D.N.J. Jun. 17, 2009) (citing psychiatrist's testimony that she would be forced to use long-acting injectable antipsychotics; only three types of antipsychotics were available in such form); United States v. Cortez-Perez, No. 06 CR 1290 WQH, 2007 WL 2695867, at *2 (S.D. Cal. Sept. 10, 2007) (ordering treatment with Haldol, a first-generation drug, after psychiatrist testified that defendant had been successfully treated with Haldol in the past with manageable side effects).

30. DSM-V, *supra* note 25, at 87–88.

31. *Id.* at 88–89.

32. *Id.* at 100–01.

33. *Id.*

34. *Id.* at 92.

35. *See* JULIEN ET AL., *supra* note 27, at 91 (discussing only schizophrenia, and no other psychotic disorders, in relation to antipsychotic drugs and noting that schizophrenia affects one percent of the population); Mossman, *supra* note 27, at 1043–44 (focusing discussion on schizophrenia).

include hallucinations, delusions, or disordered thinking.[36] Individuals suffering from disordered thinking, one of the more prominent outward symptoms of schizophrenia, jump from one topic to another, provide answers that are unrelated to questions, or are nearly incomprehensible.[37] Negative symptoms, which reflect a loss of normal functions, are more difficult to treat.[38] Affect flattening, one common negative symptom, is characterized by a lack of facial expressions, poor eye contact, and reduced body language.[39] Other negative symptoms include a lack of interest in participating in goal-directed activities and sitting still for long periods of time.[40]

Other psychotic disorders have similar symptomatic presentations to schizophrenia, but have a shorter duration (e.g., schizophreniform disorder, in which symptoms only last from one to six months) or are accompanied by additional symptoms (e.g., schizoaffective disorder, in which psychotic symptoms are accompanied by a major mood episode).[41] For example, many defendants in *Sell* hearings have been diagnosed with delusional disorder, a psychotic disorder in which a patient suffers from delusions unaccompanied by any of the other symptoms of schizophrenia.[42] Individuals suffering from delusional disorder do not express the disordered thinking or cognitive impairments known to affect schizophrenics. But for their delusions, they can be high-functioning individuals.[43] Only about 0.2 percent of the population suffers from this disorder.[44] However, they account for at least twenty-one percent of defendants in reported *Sell* cases,[45] perhaps because these individuals are associated with litigious behavior. They have been known to file multiple lawsuits or send hundreds of letters of protest to government and judicial officials.[46]

Much remains unknown about these disorders and their causes. With regard to schizophrenia, the general medical consensus is that the disorder is due, at least in part, to malfunctions in the brain because its symptoms indicate an "underlying disruption in functional neural circuitry."[47] However, there is no single biological

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36. *See* JULIEN ET AL., *supra* note 27, at 299.
37. *Id.* at 300.
38. *Id.* at 299; *see also id.* at 301.
39. *Id.* at 301.
40. *Id.*
41. *See* DSM-V, *supra* note 25, at 97–98, 106–07.
42. *See id.* at 92.
43. *Id.* at 93.
44. *Id.* at 92.
45. This number is based on a review of the seventy-seven federal district court cases decided under *Sell* through May 31, 2012. *See infa* note 143. In sixteen of those cases, defendants received an uncontested diagnosis of delusional disorder. In several other cases, testifying psychiatrists disagreed on the proper diagnosis where at least one psychiatrist believed the defendant suffered from delusional disorder.
46. DSM-V, *supra* note 25, at 92.
47. Mossman, *supra* note 27, at 1056–57 (quoting Nancy C. Andreasen, *A Unitary Model of Schizophrenia: Bleuler's "Fragmented Phrene" as Schizoencephaly*, 56 ARCHIVES GEN. PSYCHIATRY 781, 782 (1999)); *see also* Samuel Jan Brakel & John M. Davis, *Overriding Mental Health Treatment Refusals: How Much Process is*

or genetic cause of the disease. Multiple factors, including environmental ones, may contribute to the disturbances in brain function and development that result in schizophrenia.[48] There is no test that allows physicians to definitively diagnose schizophrenia,[49] and no cure exists.[50] Medication can successfully manage the positive symptoms of the disease,[51] but once a patient stops taking the medication, symptoms may return.

*2. Antipsychotic Medication*

All antipsychotics are generally effective.[52] They treat the positive symptoms of psychosis and should have a partial antipsychotic effect immediately, followed by further therapeutic effects over the course of six to eight weeks.[53] Most patients have some response to the drugs but also have continuing symptoms.[54] While the drugs usually do not achieve total remission of symptoms, between sixty and eighty percent of patients have moderate to good long-term responses to medication.[55] When it comes to the short-term restoration to competency, the outcomes are even better: eighty-seven percent of individuals improve to the point that they are able to understand the charges against them and assist their attorney in their defense.[56]

The antipsychotic medications target the positive symptoms of schizophrenia and are most effective at diminishing these symptoms. The negative symptoms of schizophrenia remain stubbornly resistant to treatment, persisting between episodes of positive symptoms.[57] Some research has indicated that second-generation antipsychotics might be more successful in treating negative symptoms, but more recent studies have contradicted this conclusion.[58]

While effective at controlling the positive symptoms of psychotic disorders, antipsychotic medications can be accompanied by significant side effects. The most common serious side effects are extrapyramidal symptoms, which are

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*"Due"?*, 51 ST. LOUIS U. L.J. 501, 508 (2008) ("[S]chizophrenia and other major mental disorders are biologically based and so, therefore, are the treatments of them.").

48. Robert Freedman, *Schizophrenia*, 349 NEW ENG. J. MED. 1738, 1739 (2003).

49. Mossman, *supra* note 27, at 1060 ("[T]he diagnosis of schizophrenia remains a 'low tech,' clinical process.").

50. DSM-V, *supra* note 25, at 102 ("[M]ost individuals with schizophrenia still require formal or informal daily living supports, and many remain chronically ill.").

51. Freedman, *supra* 48, at 1746 ("All antipsychotic drugs are effective for positive symptoms of acute psychosis.").

52. *Id.*

53. *Id.* at 1742.

54. *Id.*

55. ANTHONY J. ROTHSCHILD, THE EVIDENCE-BASED GUIDE TO ANTIPSYCHOTIC MEDICATIONS 7 (2010).

56. Brian Ladds et al., *Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Descriptive Study of the New York Experience with Judicial Review*, 21 BULL. AM. ACAD. PSYCHIATRY L. 529, 538–39 (1993).

57. DSM-V, *supra* note 25, at 102 ("Negative symptoms . . . tend to be the most persistent.").

58. JULIEN ET AL., *supra* note 27, at 97.

characterized by various movement disorders that can mimic the effects of Parkinson's disease. Akathisia, which is one such side effect, affects about twenty percent of patients taking first-generation antipsychotics.[59] Patients afflicted with this particular side effect suffer from anxiety, restlessness, pacing, constant rocking back and forth, and other meaningless repetitive actions.[60] Patients undergoing long-term treatment with the older antipsychotics are also at risk of developing a permanent neuromotor syndrome known as tardive dyskinesia, which is characterized by involuntary tongue protrusions, lip smacking, puckering of the lips, and rapid tic-like movements of the face.[61] In rare cases, patients develop a potentially fatal side effect, neuroleptic malignant syndrome, in which the patient develops a fever, severe muscle rigidity, and, in the worst cases, falls into a coma.[62]

Second-generation drugs avoid many of these more dangerous side effects. These antipsychotics, which include risperidone, olanzapine, quetiapine, and ziprasidone, treat the positive symptoms of schizophrenia as effectively as the older drugs without the accompanying danger of extrapyramidal side effects.[63] However, these drugs are not unaccompanied by risk. Individuals on the new antipsychotics can gain weight and develop diabetes, with the consequent negative impact on their long-term health.[64] Some of the second-generation anti-psychotics have also been known to cause neuroleptic malignant syndrome.[65] When choosing the antipsychotic to be used for a particular patient, psychiatrists generally prefer second-generation medications because of their more favorable side effects profile.

### *B. Legal Background*

Courts began to rule on the involuntary administration of antipsychotic medication in the 1970s, as they became the common means of treating psychotic disorders. Prior to *Sell*, two Supreme Court cases addressed the issue. In *Washington v. Harper*, the Court established that mentally ill inmates have a right to refuse antipsychotic drugs and determined this right could be overcome when the prisoner was a danger to himself or others.[66] *Riggins v. Nevada* recognized defendants in pretrial detention had the same liberty interest in freedom from unwanted medication as inmates and this interest could be overcome if the government showed the antipsychotic medication was essential to protect the

59. ROTHSCHILD, *supra* note 55, at 28.
60. *Id.*
61. *Id.*
62. JULIEN AT AL., *supra* note 27, at 106.
63. *Id.* at 96.
64. *Id.* at 117–19.
65. *Id.* at 106.
66. 494 U.S. 210, 221–22, 227 (1990).

defendant's safety or the safety of others.[67] Left unanswered was the question of whether a defendant who presented no risk of danger to himself or others could be medicated for the sole purpose of rendering him competent to stand trial. In *Sell v. United States*, the Court, relying almost solely on *Harper* and *Riggins*, held the government could involuntarily medicate such a defendant,[68] thus substantially broadening the circumstances under which a defendant could be injected with antipsychotic drugs against his will.

*1. Washington v. Harper*

Walter Harper was sentenced to prison in 1976 for robbery.[69] For the majority of his incarceration, he was housed in the Washington State Penitentiary's mental health unit, where he consented to the administration of antipsychotic drugs.[70] The government released Harper on parole in 1980 on the condition that he continue to receive mental health treatment; it revoked his parole after Harper assaulted two nurses at a hospital in Seattle.[71] Upon Harper's return to prison, psychiatrists successively diagnosed him with three mental illnesses: manic-depressive disorder, schizoaffective disorder, and schizophrenia.[72] After first consenting to take antipsychotic medication, Harper later refused these treatments.[73] The prison psychiatrist sought to medicate the prisoner under a state policy which allowed involuntary treatment if an independent committee determined that certain criteria had been met.[74] The committee approved the medication of Harper, and Harper filed suit under 42 U.S.C. § 1983, asserting the involuntary administration of antipsychotic drugs without a judicial hearing violated the Due Process, Equal Protection, and Free Speech clauses of the United States and state constitutions.[75] The question before the court was whether the administrative proceeding at the prison afforded sufficient due process, or whether a judicial hearing was required.[76]

The Washington Supreme Court decided the case in Harper's favor, finding he had a liberty interest in refusing unwanted medication, and the "highly intrusive nature" of that treatment warranted greater procedural protections than those afforded Harper under the state's procedure for administering medication.[77] The court held that only a judicial hearing, and its accompanying panoply of

67. 504 U.S. 127, 135 (1992).
68. 539 U.S. 166, 169 (2003).
69. *Harper*, 494 U.S. at 213.
70. *Id.*
71. *Id.* at 214.
72. *Id.* at 214 n.2.
73. *Id.* at 214.
74. *Id.* at 214–16.
75. *Id.* at 217.
76. *Id.* at 213.
77. *Id.* at 218.

adversarial protections, could satisfy the requirements of the Due Process Clause.[78]

The Supreme Court reversed, reasoning that the administration of unwanted medication to Harper violated neither substantive nor procedural due process protections.[79] The procedural due process issue was whether the state's non-judicial mechanisms for administering medication were sufficient; the substantive issue required that the Court define the contours of the protected constitutional interest in freedom from medication. The Court ultimately found the non-judicial proceeding satisfied the requirements of procedural due process, but, in the course of its decision, it clarified whether and when an inmate may refuse antipsychotic medication, i.e., the substantive due process issue.

On this question, the Court held that (1) an inmate has a "significant" liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause, and (2) the interest can be overcome if the inmate is dangerous to himself or others and the treatment is in the defendant's medical interest.[80] The liberty interest at stake is "not insubstantial" because the "forcible injection of medication into a non-consenting person's body represents a substantial interference with that person's liberty."[81] The Court also noted that, despite their therapeutic effects, antipsychotic drugs carry significant risks of serious, even fatal, side effects.[82]

Nevertheless, the extent of this liberty interest had to be evaluated "in the context of the inmate's confinement," and the Court recognized even fundamental rights may be limited by "legitimate penological interests."[83] In the prison context, the government had a legitimate and important interest in combating the danger posed by an inmate both to himself and to others.[84] A prison regulation that was "reasonably related" to this interest would survive due process scrutiny.[85] The policy at issue in this case allowed the medication of inmates who were mentally ill and who, as a result of their illness, were gravely disabled or represented a significant danger to themselves or others. This policy was reasonably related to the government interest in protecting a prisoner from inflicting harm upon himself or others, and the Court held that it survived due process scrutiny.[86] This case, therefore, established the right to refuse antipsychotic medication and

78. *Id.*
79. *Id.* at 218, 220–21.
80. *Id.* at 221–22, 227.
81. *Id.* at 229.
82. *Id.*
83. *Id.* at 222–23.
84. *Id.* at 225.
85. *Id.* at 223 (quoting Turner v. Safley, 482 U.S. 78, 89 (1987)).
86. *Id.* at 227.

identified circumstances under which intrusion upon that right would not violate due process.[87]

*2. Riggins v. Nevada*

Left unanswered by *Harper* were the questions of whether defendants in pre-trial detention—individuals who, unlike inmates, had not been convicted of any crime—possessed the same interest in freedom from unwanted medication, and when government interests could override this right. In *Riggins v. Nevada*, the Supreme Court determined the Due Process Clause affords at least as much protection to individuals detained for trial as it does for inmates.[88]

David Riggins was accused, and ultimately convicted, of stabbing and killing Paul Wade in the early morning hours of November 20, 1987.[89] Riggins presented an insanity defense at trial and testified that he heard voices in his head that said killing Wade was justified.[90] At the time he testified, he was being given 800 milligrams a day of Mellaril, an antipsychotic drug.[91] He originally consented to the administration of the drug, but later moved for a court order suspending the use of Mellaril until the end of his trial.[92] The district court denied the motion in a one-page order that did not provide its rationale.[93]

Riggins appealed the case to the Nevada Supreme Court, arguing that the government intruded upon his right to freedom from unwanted medication and the forced administration of Mellaril interfered with his right to a fair trial because it "denied him the ability to assist in his own defense and prejudicially affected his attitude, appearance, and demeanor at trial."[94] The Nevada Supreme Court rejected these arguments, holding that, although Riggins' unmedicated demeanor was relevant to his insanity defense, the denial of the defense's motion to terminate medication was neither an abuse of discretion nor a violation of Riggins' trial rights because an expert witness informed the jury of the effects of Mellaril on the

87. *Id.* at 221–22, 225–27. In a lengthy dissent to the Court's evaluation of the merits, Justice Stevens argued the majority undervalued the significance of the right to refuse the administration of antipsychotic drugs, believing this fundamental liberty interest to be "deserving [of] the highest order of protection." The dissent identified three different dimensions of the liberty interest: (1) a bodily intrusion that created a substantial risk of permanent injury and premature death; (2) a degrading action that overrode a competent person's choice to reject a specific form of medical treatment; and (3) a forced alteration of the will and mind of the subject, which Justice Stevens called "a deprivation of liberty in the most literal and fundamental sense." Because the policy at issue did not adequately protect this fundamental right, the decision of the Washington Supreme Court should have been affirmed, Justice Stevens argued. *Id.* at 237–38, 241 (Stevens, J., concurring in part and dissenting in part).

88. 504 U.S. 127, 135 (1992).

89. *Id.* at 129, 131.

90. *Id.* at 131.

91. *Id.*

92. *See id.* at 129–30 (explaining it was Riggins who first mentioned the Mellaril treatment).

93. *Id.* at 131.

94. *Id.*

defendant's demeanor and testimony.[95] The court did not consider whether the Due Process Clause was violated by the administration of medication, and it affirmed Riggins' conviction and death sentence.[96]

The Supreme Court reversed, finding the Sixth and Fourteenth Amendments were violated. It held there was "a strong possibility Riggins' defense was impaired due to the administration of Mellaril" because it might have had an impact on his outward demeanor, the content of his testimony, and his ability to communicate with counsel.[97] The Court also considered the due process question that went unaddressed in the lower courts and found no evidence to support the conclusion that the administration of Mellaril was necessary to accomplish an essential state policy.[98] The Court applied the *Harper* standard to detained individuals and stated the government would have satisfied the requirements of the Due Process Clause if it had shown the administration of medication was necessary for the sake of the defendant's safety or the safety of others.[99]

While the potential trial prejudice and the failure to consider the due process question was sufficient for the Court to reverse the Nevada Supreme Court, it noted in dicta that another kind of showing *might* satisfy the strictures of due process—a showing that the State could not obtain an adjudication of Riggins's guilt or innocence by using less intrusive means.[100] In other words, if Riggins was not dangerous, the government's interest in bringing Riggins to trial may have justified involuntary treatment. The Court skirted a decision on whether this government interest would suffice because Riggins did not argue in the lower courts that he had a right to refuse the Mellaril if the discontinuation of the drug rendered him incompetent; he only argued administration of the drug denied him a full and fair trial.[101]

Justice Kennedy, concurring in the judgment, focused on the possibility that a defendant could be forced to take medication for the sole purpose of rendering him competent to stand trial.[102] He believed the government had to make an extraordinary showing in those circumstances to satisfy the Due Process Clause and he had "doubt[s] that the showing can be made in most cases, given our present understanding of the properties of these drugs."[103] Justice Kennedy reached this conclusion because he believed the government must show "there is no significant risk that the medication will impair or alter in any material way the defendant's

95. *Id.* at 132.
96. *See id.*
97. *Id.* at 137.
98. *Id.* at 138.
99. *Id.* at 135.
100. *Id.*
101. *Id.* at 136.
102. *Id.* at 138–39.
103. *Id.* at 139.

capacity or willingness to react to the testimony at trial or to assist his counsel."[104]

Justice Kennedy explored those risks in depth and expressed particular concern about the potential of the medication to alter a defendant's demeanor and ability to cooperate with counsel.[105] These side effects have the potential to "prejudice all facets of the defense," raising serious due process concerns about government manipulation of the evidence (the evidence being the defendant himself).[106] The concurrence held up as one example the chance that the medication could cause the defendant to be restless and unable to sit still. This kind of behavior might create a negative impression in the trier of fact, which "can have a powerful influence on the outcome of the trial."[107]

Absent a showing "that the side effects will not alter the defendant's reactions or diminish his capacity to assist counsel," the government must resort to involuntary commitment—not involuntary medication—in the vast majority of cases of incompetence, Justice Kennedy argued.[108] If the defendant cannot be tried without involuntary treatment and its accompanying impact on the defendant's demeanor, then, in Justice Kennedy's view, society must "bear this cost in order to preserve the integrity of the trial process."[109]

Justice Kennedy's concurrence, upon which the later *Sell* decision heavily relied, primarily focused on the side effects of antipsychotic drugs and their potential impact on a defendant's demeanor during trial and his ability to assist counsel. The *Sell* decision's overwhelming concern with side effects—two of the four factors of the *Sell* test are related in some way to that question—is derived mainly from this concurrence. But, as discussed in Part II, the formulation of these factors in *Sell* left much room for the government to overcome a court's concerns about side effects, whereas Justice Kennedy doubted such a showing could ever be made.[110]

## II. *SELL V. UNITED STATES*

With the case of Charles Thomas Sell, the Supreme Court addressed the question that remained unanswered in *Riggins*: whether a defendant had the right to refuse antipsychotic medication when the government's only purpose in administering that medication was to render the defendant competent to stand trial. It concluded that, like Harper and Riggins, Sell did possess such a right, but if an

104. *Id.* at 141.
105. *Id.* at 143–45.
106. *Id.* at 142.
107. *Id.*
108. *Id.* at 143.
109. *Id.* at 145.
110. Justice Thomas filed a dissent in *Riggins*, in which he stated the Supreme Court should not consider Riggins' due process argument because it had not been raised in the courts below, but should instead focus only on whether Riggins had a full and fair trial. *Id.* at 152. Because Riggins did have the fundamentally fair trial guaranteed by the Constitution, the conviction should be affirmed, Justice Thomas argued. *Id.* at 146.

"important" government interest were at stake and other criteria—such as ensuring the defendant would not suffer from side effects that would interfere with his ability to assist counsel—were met, the government could force the medication upon the defendant without violating the Due Process Clause.

Petitioner Sell was a troubled dentist who believed the gold he used for fillings was contaminated by Communists, and he once called the police to report a leopard outside his office, boarding a bus.[111] He was hospitalized for psychotic symptoms on at least two occasions.[112] In May 1997, the government charged Sell with submitting fictitious insurance claims for payment.[113] A federal magistrate judge found Sell currently competent, but added the caveat that Sell might experience a psychotic episode in the future.[114] The judge released Sell on bail.[115] The following year, the government claimed Sell had sought to intimidate a witness.[116] At the bail revocation hearing, Sell was "totally out of control," hurling "personal insults" and "racial epithets" and spitting in the judge's face.[117] The magistrate revoked Sell's bail.[118]

In early 1999, Sell asked the magistrate to reconsider his competence to stand trial.[119] After evaluation at the United States Medical Center for Federal Prisoners at Springfield, Missouri, the magistrate found Sell was mentally incompetent to stand trial and ordered him hospitalized for treatment.[120] Two months later, staff at the Medical Center recommended that Sell take antipsychotic drugs, which he refused to do.[121] The magistrate judge ordered the involuntary medication, concluding "anti-psychotic medications are the only way to render the defendant not dangerous and competent to stand trial."[122] The district court overturned the magistrate's conclusion that Sell was dangerous, but affirmed the order on the basis that the drugs were medically appropriate, represented the only viable hope of rendering the defendant competent to stand trial, and were necessary to serve the government's interest in obtaining adjudication of the defendant's guilt or innocence.[123] The Eighth Circuit affirmed the district court's order.[124]

The Supreme Court, in an opinion authored by Justice Breyer, looked to *Harper* and *Riggins* (including Justice Kennedy's *Riggins* concurrence) to answer

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111. Sell v. United States, 539 U.S. 166, 169 (2003).
112. *Id.* at 169–70.
113. *Id.* at 170.
114. *Id.*
115. *Id.*
116. *Id.*
117. *Id.*
118. *Id.*
119. *Id.*
120. *Id.* at 171.
121. *Id.*
122. *Id.* at 173.
123. *Id.* at 174.
124. *Id.* at 172–75.

the question of whether forced administration of antipsychotic drugs to render a defendant competent to stand trial unconstitutionally deprived a defendant of his right to refuse the medication. From these cases, the Court concluded such medication was permissible, but only when: (1) important government interests were at stake; (2) involuntary medication would significantly further those interests; (3) involuntary medication was necessary to further those interests; and (4) administration of the drugs was medically appropriate.[125] The Court cautioned that circumstances in which all four factors were met "may be rare."[126]

This prediction was due to the specific—and, in the Court's view, difficult—showings the government needed to make under each of the four factors. First, the government must show that important government interests are at stake, and the Supreme Court stated the government had an important interest in trying those accused of serious crimes against persons or property.[127] The Court failed to define what qualified as a "serious" crime, and lower courts have since struggled to identify the crimes that clear this bar. The two major approaches to evaluating the severity of the crime are (1) whether the defendant is entitled to a jury trial, meaning the maximum possible penalty is over six months imprisonment, and (2) whether the crime is against persons or property.[128] Regardless of which measure courts use, this standard is generally met. Only four of the seventy-seven cases analyzed for this Article involved crimes the court held were not serious.[129]

The *Sell* opinion also contained a caveat: even when faced with a serious crime, courts must consider the "facts of the individual case" when evaluating the importance of the government interest.[130] The Court identified two such circumstances when the importance of the government interest could be lessened: (1) the defendant had already been confined for a significant period of time, for which he would receive credit for any sentence eventually imposed, and (2) the defendant would potentially be confined for a lengthy period to an institution for the mentally ill.[131] The Court also noted the government has a "concomitant, constitutionally essential interest" in ensuring the defendant's trial is fair.[132]

These circumstances are only examples. Other circumstances, not specifically listed in the decision, could also potentially weaken the government's

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125. *Id.* at 180–81.

126. *Id.* at 180.

127. *Id.*

128. *See, e.g.*, United States v. Evans, 404 F.3d 227, 237 (4th Cir. 2005) (using maximum statutory term of imprisonment when holding the crime of threatening a federal judge serious); United States v. Barajas-Torres, No. CRIM.EP-03-CR-2011KC., 2004 WL 1598914, at *3 (W.D. Tex. Jul. 1, 2004) (holding crime of illegal reentry was not serious because it was not a crime against persons or property); *see also* David M. Siegel, *Involuntary Psychotropic Medication to Competence: No Longer an Easy* Sell, 12 MICH. ST. U.J. MED. & L. 1, 8 (2008).

129. *See infra* Part III.

130. Sell v. United States, 539 U.S. 166, 180 (2003).

131. *Id.*

132. *Id.*

interest. Courts therefore must look at *all* of the facts of the individual case when determining the relative strength of the government interest. For example, a court may look to the facts surrounding the crime—such as whether the crime itself appears to be a manifestation of the individual's mental illness—to determine whether the government's interest in prosecuting the defendant is sufficiently important. As discussed further in Part IV, a handful of courts have already proceeded down this path,[133] while some scholars have advocated this analysis as a backdoor means of decriminalizing mental illness.[134] *Sell* allows for consideration of such facts under the important government interest factor.

Second, for a court to find that involuntary medication will significantly further important state interests, it must find the administration of the drugs is both substantially likely to render the defendant competent to stand trial and substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense.[135] Here, the Court cited Justice Kennedy's concurrence in *Riggins*, but substantially weakened the standard set out in the concurrence. The Court's concern about side effects was restricted to those effects that interfered with the defendant's ability to assist counsel. The Court neglected to mention Justice Kennedy's concern about the medication's impact on a defendant's demeanor and the consequent jury prejudice that may arise.[136] Also, under *Sell*, the government need only show that it is *substantially unlikely* that the defendant will suffer the relevant side effects. Justice Kennedy's concurrence would bar medication altogether unless the government could show the medication *will not* alter the defendant's reactions or diminish his capacity to assist counsel.[137]

Third, medication is necessary to further government interests only if any alternative, less intrusive treatments are unlikely to achieve substantially the same results.[138] If nondrug therapy may be effective in restoring the defendant to competence, that avenue must first be exhausted. A court must also first consider less intrusive means for administering the drugs, such as a court order requiring the medication, before resorting to methods more intrusive upon the body.[139] However, the Court neglected to mention that both *Harper* and the *Riggins* concurrence found that no alternative means are as effective at controlling psychotic symptoms

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133. *See* United States v. Weinberg, 743 F. Supp. 2d 234, 237 (W.D.N.Y. 2010) (finding the government did not have an important interest in prosecuting the defendant for threatening a judicial officer when "such a threat seems quite consistent with Weinberg's illness . . . ."); United States v. Lindauer, 448 F. Supp. 2d 558, 571–72 (S.D.N.Y 2006) (finding the government did not have an important interest in prosecuting a defendant for acting as an agent of the Iraqi government when "even lay people recognize she is seriously disturbed").

134. *See* Gregory B. Leong, Sell v. U.S.: *Involuntary Treatment Case or Catalyst for Change?*, 33 J. AM. ACAD. PSYCHIATRY & L. 292, 293 (2005).

135. *Sell*, 539 U.S. at 181 (citing Riggins v. Nevada, 504 U.S. 127, 142–45 (Kennedy, J., concurring)).

136. *Id.*

137. *Riggins*, 504 U.S. at 143.

138. Sell v. United States, 539 U.S. 166, 181 (2003).

139. *Id.*

as antipsychotic drugs.[140] Practically, no other means work at all. This factor is therefore easily met in nearly all cases.

Fourth, the court must conclude the drugs are medically appropriate, meaning they are in the best medical interest of the patient in light of his condition. The analysis here is broader than that contained in the second factor because a court must consider all the side effects, not only the ones that impair a defendant's ability to assist his counsel. Here, courts must take a close look at the specifics of the drugs involved because "[d]ifferent kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success."[141]

When framing the relevant question, the Court placed its focus on these final three factors: whether 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," showed a need for that treatment "sufficiently important" to overcome the individual's protected interest in refusing it.[142] Since the *Sell* decision, the question of the relative importance of the government interest has been lost in a blizzard of information about efficacy, side effects, and medical appropriateness. The end result: the approval of unwanted medication in over sixty-three percent of cases.

## III. MISREADING *SELL*

The application of this test has not resulted in the "rare" instances of involuntary medication contemplated by the Court. Rather, as of May 31, 2012, federal district courts granted motions to medicate in forty-nine of seventy-seven cases, a success rate of just over sixty-three percent.[143] The majority of these defendants allegedly committed crimes involving no physical damage to people or property, and the crimes at issue were often a clear manifestation of the individual's mental disorder.

See, for example, the case of Denise Gail Kimball, who believed voices on television were warning her of dire events, which she needed to report to law enforcement.[144] She told the court that she had successfully predicted several events in the past, including a sniper attack in New Jersey, a widespread computer

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140. *See Riggins*, 504 U.S. at 141 (Kennedy, J., concurring) ("For many patients, no effective alternative exists for treatment of their illnesses."); Washington v. Harper, 494 U.S. 210, 226 (1990) ("[T]here is little dispute in the psychiatric profession that proper use of the drugs is an effective means of treating and controlling a mental illness . . . .").

141. *Sell*, 539 U.S. at 181.

142. *Id.* at 183.

143. This number was calculated by identifying federal district court cases reported via Lexis Advance and WestlawNext that cited to *Sell* and (1) addressed the substantive involuntary medication issue (i.e., cases using *Sell* for its analysis of the collateral order doctrine were excluded), (2) were in the context of rendering individuals competent to stand trial (i.e., post-conviction cases, such as those involving parole violations, were excluded), and (3) granted or denied the government's motion to medicate (i.e., cases that ordered further briefing or were decided on non-*Sell* grounds (rendering the medication issue moot) were excluded).

144. United States v. Kimball, No. CR03-1025, 2004 WL 3105948, at *2 (N.D. Iowa Mar. 23, 2004).

virus, and the sinking of a ship in the Atlantic Ocean.[145] The government charged Kimball with willfully providing false information concerning a threatened attack on a mass transportation facility.[146] The district court ordered her medicated.[147]

Another example may be found in the case of Barbara Michelle Bush, who was charged with two counts of threatening a federal judge while she was pursuing a civil pro se lawsuit. By her own account, she had filed over 100 such lawsuits.[148] Bush sent a letter, unrelated to the litigation, to three federal judges, which quoted a 1907 treatise on self-defense. Her letter read:

> Barbara Michelle Bush's intentional infliction of (or, if she misses, her intent to inflict) physical harm upon the other . . . is said to be justified when she acts in proper self-defense against [three federal judges] . . . .
>
> Thus, according to Maryland criminal law, Barbara Michelle Bush may slay any of such persons or all of them, if it reasonably appears to her to be necessary so to do to protect herself from anymore great bodily harm or death.[149]

Bush sent the same language in a second letter to the district court, this time with the words "NO THREAT" written in bold across the top of the page.[150] After the second letter, Bush was arrested and charged with two counts of threatening a federal judge.[151] Bush argued she had no intent to commit the crime because the government's psychiatrists concluded Bush was likely suffering from delusions at the time she sent these letters.[152] The district court ordered her medicated.[153]

*Bush* and *Kimball* are not outliers. A large percentage of these cases involve mentally disturbed individuals doing mentally disturbed things, such as making nonsensical threats against federal officials or warning of non-existent impending disasters. For example, fifteen out of the forty-nine federal cases in which the defendant was ordered medicated, or almost one-third of the cases, involved the crime of threatening a federal official or threatening property (such as a false bomb threat). While these cases might teeter on the brink of crimes of violence, the very fact that these individuals are facing *Sell* hearings, rather than being medicated

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145. *Id.*
146. *Id.* at *1.
147. *Id.* at *5.
148. United States v. Bush, 585 F.3d 806, 809–10 (4th Cir. 2009).
149. *Id.* at 810.
150. *Id.*
151. *Id.* at 811.
152. *Id.* at 814.
153. *Id.* at 813. On appeal, the Fourth Circuit concluded the special circumstances of the case—including the likelihood that the government would not be able to prove the requisite intent—were outweighed by the important governmental interest in bringing Bush to trial. It nevertheless vacated the district court's order and remanded for further proceedings because the district court had not applied a clear and convincing standard to the evidence—the standard set by the Fourth Circuit for the first time in *Bush*—and because the treatment plan failed to provide adequate detail about the drugs and side effects of the medication that would be administered to Bush. *Id.* at 814–15.

under the *Harper* dangerousness standard, indicates that mental health professionals do not believe these individuals were likely to carry out their threats. Instead, these crimes are nothing more than an outward manifestation of the symptoms of mental illness, activity undertaken in response to the delusions associated with schizophrenia or delusional disorder. They may be "serious" crimes—courts defined them as such when they ordered defendants medicated—but the fact that these individuals are in the criminal justice system, rather than mental hospitals, is a symptom of the criminalization of mental illness and the malfunctioning of the mental health system,[154] extensive problems that are beyond the scope of this Article.

While *Sell* did not address those deep systemic issues, it did create an off-ramp within the government interest factor so that these defendants did not need to suffer through years of incarceration and medication against their will.[155] But the issuance of so many medication orders in *Bush*- and *Kimball*-like cases indicates courts are not taking advantage of this approach. These skewed outcomes are occurring for two reasons: (1) courts overemphasize the questions surrounding the efficacy of the medication and its side effects, which will almost always be decided in the government's favor, and (2) courts underemphasize the question of whether the government's interest is important.

### *A. Overemphasis on Medication and Side Effects*

Three of the four *Sell* factors are medical considerations: whether the drug is likely to work without producing significant side effects, whether there are any other options for treatment, and whether the drug is medically appropriate for the patient. In the vast majority of cases, the evidence on each of these factors will support medicating the defendant.[156] Because these factors take up three of the

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154. *See generally* PETE EARLEY, CRAZY: A FATHER'S SEARCH THROUGH AMERICA'S MENTAL HEALTH MADNESS (2006); E. FULLER TORREY ET AL., CRIMINALIZING THE SERIOUSLY MENTALLY ILL: THE ABUSE OF JAILS AS MENTAL HOSPITALS (1992).

155. Several scholars have argued the *Sell* test is misguided because it places too many barriers to involuntary medication and does not serve the best medical interests of the defendants, who would benefit from treatment. *See, e.g.*, Samuel Jan Brakel & John M. Davis, *Overriding Mental Health Treatment Refusals: How Much Process Is "Due"?*, 52 ST. LOUIS U. L.J. 501, 566–68 (2008). Brakel and Davis, for example, recommend a "medical" approach to involuntary medication that would allow physicians to treat defendants if such treatment is medically proper. *Id.* at 585. While this argument is compelling—treatment with antipsychotics would almost undoubtedly improve the lives of defendants—implementation would require a substantial overhaul of the involuntary medication regime and reversal of several Supreme Court precedents. This Article takes no position on whether defendants would be better off if the barriers to involuntary medication were loosened; they well might be. Instead, this Article looks specifically at involuntary medication for the purpose of restoring competence for trial and determines whether the *Sell* test is being effectively implemented, given the Supreme Court's suggestion that orders in such circumstances will be rare and stating a preference for using other avenues that justify involuntary medication. Solutions to the more extensive problem of the undermedication of mentally ill individuals are beyond the scope of this Article.

156. *See* Dora W. Klein, *Curiouser and Curiouser: Involuntary Medications and Incompetent Criminal Defendants After* Sell v. United States, 13 WM. & MARY BILL RTS. J. 897, 906–14 (2005).

four steps of the analysis, and they will almost always be met, defendants find themselves fighting an uphill battle to avoid medication. These factors have placed undue emphasis on whether the medication will work and what the side effects will be, at the expense of considering whether it should be administered at all.

*1. Efficacy and Side Effects*

When courts analyze whether the drugs will significantly further government interests, they need to answer two questions. First, are the drugs substantially likely to return the defendant to competency?[157] Second, are they substantially unlikely to have side effects that hamper the defendant's ability to assist counsel?[158] The medication works for most psychotic individuals; therefore, the *Sell* inquiry requires that courts determine whether a defendant is in that small percentage of individuals who do not respond to medication or who suffer serious side effects. Yet, unless the defendant has been treated with the proposed antipsychotic in the past, it is difficult to predict with certainty what the outcome for that defendant will be.[159] Psychiatrists and courts therefore justifiably rely on the averages.

Antipsychotics generally work. Psychiatrists testifying in *Sell* cases have generally relied on personal experience and studies as support for this conclusion. In *United States v. Algere*, for example, the court found this element was met when the testifying psychiatrist relied on (1) a seventy to eighty percent success rate in her personal experience with treating patients; (2) a New York study that found eighty-seven percent of involuntarily medicated felony defendants were restored to competency; and (3) the American Psychiatric Association's "Practice Guidelines for the Treatment of Patients with Schizophrenia," which indicated that seventy percent of first-episode schizophrenics achieve remission of psychotic symptoms after three to four months of treatment with antipsychotics.[160] Psychiatrists testifying in other cases with schizophrenic defendants have relied on some combination of similar sources. Courts have found these sources sufficient to support a conclusion that antipsychotics are substantially likely to return a defendant to competence.[161]

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157. Sell v. United States, 539 U.S. 166, 181 (2003).

158. *Id.*

159. *See* Klein, *supra* note 156, at 910–11. *But see* Douglas Mossman, *Predicting Restorability of Incompetent Criminal Defendants*, 35 J. AM. ACAD. PSYCHIATRY & L. 34, 41 (2007) (identifying two circumstances in which a defendant has a low chance of restoration to competency: (1) when defendant has long-standing psychiatric disorder that has resulted in lengthy periods of hospitalization and (2) when defendant has an irremediable cognitive disorder, such as mental retardation).

160. 396 F. Supp. 2d 734, 742–43 (E.D. La. 2005).

161. *See, e.g.*, United States v. Gomes, 387 F.3d 157, 161–62 (2d Cir. 2004) (holding district court's reliance on Bureau of Prison's seventy percent success rate in treating patients was not clearly erroneous); United States v. Bedros, No. 06-249 (NGG), 2008 WL 2437865, at *2 (E.D.N.Y. June 13, 2008) (relying on government psychiatrist's testimony that, based on his personal experience, schizophrenic patients have an eighty percent

Antipsychotics also generally do not result in side effects that interfere with a defendant's ability to assist counsel, although the outcomes here are much less certain than with the effectiveness of the medication, given the plethora of possible side effects and the inability to predict which side effects will strike which defendants. For example, twenty percent of patients on first-generation antipsychotics suffer from the symptom of akathisia, which is characterized by restless movements.[162] A court has no way of predicting which patients will fall into that twenty percent. And if the twenty percent is too high a risk for this defendant, it must be too high a risk for all defendants—prohibiting the medication of every defendant in every case.[163]

Despite the fact that these medications generally work and generally are not accompanied by uncontrollable side effects, this factor has been the most litigated among the four factors. Many courts, frustrated by the generalities inherent in the efficacy predictions, have required more specificity before authorizing involuntary medication. The Ninth Circuit, for example, requires district courts to make specific findings about the drug's impact on a particular patient.[164] It stated:

> It does not follow that because the use of a product is designed to accomplish an end, it does so. Nor does it follow that it is substantially likely that it will do so, let alone substantially unlikely that it will have unintended adverse effects. Because the second factor of the *Sell* test requires the government to show by clear and convincing evidence what it is substantially likely that the involuntary medication regimen *will do* (and what it is substantially likely that it will not do), the government cannot satisfy its burden by showing what the involuntary medication regimen is *designed to do*.[165]

What this decision fails to recognize is that psychiatrists are usually armed with little more information than what the medication is designed to do. Unless the

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chance of competency restoration; he later revised that estimate down to sixty percent because the defendant had schizophrenia, disorganized type, which was not addressed in the literature).

162. *E.g.*, ROTHSCHILD, *supra* note 55, at 28.

163. There is also some question of whether akathisia and the other motor control side effects associated with antipsychotics would be side effects that would affect the defendant's ability to assist counsel. The Supreme Court seemed most concerned with potential sedative side effects of antipsychotics. *See* Sell v. United States, 539 U.S. 166, 185 (2003) ("Whether a particular drug will tend to sedate a defendant, interfere with communication with counsel, prevent rapid reaction to trial developments, or diminish the ability to express emotions are matters important in determining the permissibility of medication to restore competence . . . ."). Few courts have acknowledged that the list of side effects that may fall into the category of those that interfere with the defendant's ability to assist counsel may be small. *But see* United States v. Mesfun, No. 05-858 (WHW), 2009 WL 1704308, at *18 (D.N.J. June 17, 2009) (discounting evidence of side effects because none of the side effects in the record would impact a defendant's ability to assist counsel).

164. United States v. Ruiz-Gaxiola, 623 F.3d 684, 696 (9th Cir. 2010); *see also* United States v. Hernandez-Vasquez, 513 F.3d 908, 916–17 (9th Cir. 2007) (finding that, at a minimum, an involuntary medication order must include the medication to be administered, the maximum dosage, and the length of time that treatment may continue).

165. *Ruiz-Gaxiola*, 623 F.3d at 696.

defendant has taken the medication previously, there is no certainty as to what the medication will do, only what it is likely to do. The kind of individualized assessment desired by the Ninth Circuit in this case more properly belongs in the court's analysis of the government interest factor, as argued in Part IV below.

*2. Alternatives to Treatment*

With the third factor, whether the medication is necessary to further government interests, the government needs to show that no alternative, less intrusive treatments will restore a patient to competency.[166] Barring truly unusual circumstances, this factor will be met. Only antipsychotics can help a defendant achieve competence; there is simply no other method that works as well.[167] As many psychiatrists have testified, the major alternative—talk therapy—is unlikely to work because, as one court stated, "a patient has to be receptive to that kind of therapy for it to be effective."[168] Defendants "who have a distorted perception of reality," as most defendants suffering from psychotic symptoms do, are generally not receptive to therapy.[169] Even psychiatrists testifying on behalf of the defendant have admitted there is little chance of success with any avenue of treatment other than antipsychotic medication. As one district court succinctly stated, "[o]n this point, the experts are united: there is no other alternate treatment that is likely to achieve substantially the same result . . . ."[170] Therefore, this factor, too, should fall in the government's favor in nearly every case.

*3. Medically Appropriate*

Under the final factor, the government needs to show that the drugs are medically appropriate, or "in the patient's best medical interest in light of his medical condition."[171] This question, too, will usually be decided in favor of the government. The analysis under this factor is somewhat broader than the side effects question in the second factor, which is only limited to those side effects that will hamper the defendant's ability to assist counsel.[172] Despite this different formulation of the consideration, the test will still be satisfied in nearly every case.

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166. *Sell*, 539 U.S. at 181.

167. Some courts first require the defendant be presented with a court order backed by the court's contempt power in an effort to force the defendant to take the medication. *See, e.g.*, United States v. Burhoe, 692 F. Supp. 2d 137, 144–45 (D. Me. 2010). To the extent that this is defined as an "alternative" treatment, it is the only one that potentially could restore a defendant to competency. However, this method often does not work for the same reason talk therapy does not work: it requires a willing defendant. *See* United States v. Algere, 396 F. Supp. 2d 734, 745 (E.D. La. 2005) ("Considering that Algere remains incompetent, continues to refuse all medication and has indicated that he thinks the Court is part of a conspiracy against him, a Court order threatening contempt would be unlikely to affect Algere's willingness to take the medication.").

168. *Algere*, 396 F. Supp. 2d at 745.

169. United States v. Gomes, 387 F.3d 157, 162 (2d Cir. 2004).

170. United States v. Decoteau, 857 F. Supp. 2d 295, 306 (E.D.N.Y. 2012).

171. Sell v. United States, 539 U.S. 166, 181 (2003).

172. *See supra* note 163 and accompanying text.

Courts have largely deferred to psychiatrists' testimony that antipsychotic medications are the standard—and likely the only—treatment for schizophrenia and other psychotic disorders. In *United States v. Algere*, for example, the court agreed with the psychiatrist's report, stating "[a]ntipsychotic medication is the standard treatment for [defendant's] condition . . . ."[173] In *United States v. Gomes*, the court found the administration of antipsychotics to be medically appropriate, citing to the treating psychiatrist's testimony that the defendant's condition "is such that he needs . . . treatment [with] anti-psychotics. It is medically appropriate to treat a debilitating illness."[174]

Moreover, some courts have found this factor to be satisfied by reasoning that the medication not only advances the government's interests, but also is in the best interests of the patient. In *United States v. Milliken*, for example, the court found this factor satisfied when it considered the benefits medication would have for the defendant's long-term health ("if not treated, Defendant's condition may worsen") and his trial strategy ("antipsychotic medication will help the Defendant assist his counsel by making his delusions less prominent").[175] The same benefits accrue to any defendant ordered to take medication.

While it is true that psychotic disorders are debilitating and medication is generally an appropriate treatment, some defendants with certain medical issues may be more at risk of particular side effects. For example, second-generation antipsychotics may exacerbate a diabetic's condition.[176] Yet, even in these instances, psychiatrists regularly testify that they can monitor the side effects of drugs and adjust treatment plans if the side effects become severe. Courts have accepted these explanations as sufficient to satisfy this factor.[177] Thus, even in circumstances where there may be some question as to whether the administration of the drug is medically appropriate, involuntary medication is being approved.

There are few instances where it would be "medically appropriate" to leave schizophrenia or other psychotic disorders untreated. These drugs are in wide use exactly because they are "medically appropriate" for these individuals. For that reason, this factor, too, will usually be satisfied.[178]

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173. United States v. Algere, 396 F. Supp. 2d 734, 745–46 (E.D. La. 2005); *see also, e.g.*, United States v. Aleksov, No. 08-057-M (AK), 2009 WL 1259080, at *3 (D.D.C. May 7, 2009) ("[T]he Court concludes that the administration of medication is medically necessary, as it is the common and standard course of treatment for Defendant's psychotic condition.").

174. *Gomes*, 387 F.3d at 163.

175. No. 3:05-cr-6-J-32TEM, 2006 WL 2945957, at *14 (M.D. Fla. Jul. 12, 2006).

176. JULIEN ET AL., *supra* note 27, at 96.

177. *See* United States v. Bedros, No. 06-249 (NGG), 2008 WL 2437865, at *2, *4 (E.D.N.Y. June 13, 2008); United States v. Archuleta, No. 2:05CR0676 TC, 2006 WL 2476070, at *4 (D. Utah Aug. 24, 2006).

178. *See* Dora W. Klein, *Unreasonable: Involuntary Medications, Incompetent Criminal Defendants, and the Fourth Amendment*, 46 SAN DIEGO L. REV. 161, 192–93 (2009) ("All antipsychotics do have the potential to cause very disabling and even life-threatening side effects. But given that schizophrenia is itself very disabling and even life-threatening, it is the rare person with schizophrenia for whom antipsychotic medications can be declared medically inappropriate.") (footnotes omitted).

### *B. Underemphasis on Facts of the Individual Case*

In the majority of cases, the decision on the final three factors should not be a close call, and the court can check off three of the four boxes of the *Sell* test. However, the court still must determine whether the government interest at stake is "important." And it is here that the Supreme Court required that courts take the defendant's individual circumstances into account. Government interests must be considered in light of the "facts of the individual case," and "special circumstances may lessen" the importance of the interest.[179] However, courts have largely neglected this individualized assessment in favor of a more streamlined analysis. Under the approach favored by many courts, an interest is judged important if the crime is "serious" and the two "special circumstances" identified in *Sell* are not present.

Courts have consistently held that the charges faced by the defendants are serious, an unsurprising result because "[n]early every felony can be described as 'serious.'"[180] Evidence of this default position comes from the cases themselves. Since *Sell* was decided, courts in only four out of seventy-seven cases have held that a crime was not serious. Courts have called "serious" crimes as varied as credit card fraud, sending threats via fax, and illegal reentry.[181]

The critical question, then, becomes whether the government's interest in prosecuting a serious crime is lessened due to the facts of the individual case. The Court proposed two possible circumstances that might undermine this interest: when the defendant could be subject to a lengthy civil commitment, and when the defendant has already been confined for a significant period of time. However, it did not restrict lower courts to those two possibilities.[182] It also noted its concern with broader questions of fairness and purpose, stating the defendant's trial must be "a fair one," and noting courts must consider whether "bringing such an individual to trial *alone* justif[ies] in whole (or at least in significant part) administration of a drug that may have adverse side effects, including side effects that may to some extent impair a defense at trial . . . ."[183]

Yet, few lower courts have considered this issue beyond a mention of the two special circumstances set out by the Supreme Court. While the Court envisioned an all-encompassing analysis of the "facts of the individual case" when determining whether the government's interest in prosecution is sufficiently important to justify medication, the analysis in the lower courts has fallen far below that bar.

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179. United States v. Sell, 539 U.S. 166, 180 (2003).

180. United States v. Schloming, No. 05-5017 (TJB), 2006 WL 1320078, at *6 (D.N.J. May 12, 2006).

181. United States v. Nicklas, 623 F.3d 1175, 1178 (8th Cir. 2010) (discussing the transmission of a threatening communication in interstate commerce); United States v. White, 620 F.3d 401, 410–11 (4th Cir. 2010) (discussing credit card fraud); United States v. Sanchez-Cruz, No. EP-07-CR-144-DB, 2007 WL 4190692, at *3 (W.D. Tex. Nov. 19, 2007) (discussing illegal reentry).

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

183. *Id.* at 183 (emphasis in original).

In *Kimball*, for example, the court found the government had an important interest in prosecuting a delusional defendant who tried to provide an airline with information about an upcoming attack on mass transit. The supposedly impending attack was the product of the defendant's delusional belief that she was receiving messages through voices on her radio and television.[184] The court's conclusion that prosecuting this defendant was "undoubtedly important" was based on nothing more than the fact that the maximum prison term for the charge was twenty years.[185] The court did not consider whether the defendant's individual circumstances—in particular, the fact that her crime was the direct result of her delusions—lessened the government's interest in prosecuting her.

A similar situation occurred in *Bush*. In that case, the court did not consider whether the defendant's individual circumstances, particularly her delusional state at the time she sent the letters, lessened the importance of the government's interest in prosecuting the case. The government conceded that Bush was likely delusional when she sent the letters, labeled "NO THREAT," to the federal judges.[186] That fact went unconsidered. Instead, the court found that, even though there was a strong possibility that Bush would only be sentenced to time served, the government interest remained important because (1) prosecuting her for this conduct sent a message about its seriousness; (2) a conviction would subject Bush to a period of supervised release; and (3) a conviction would lead to restrictions on certain activities, like owing a firearm.[187] The court gave no consideration to the defendant's individual circumstances and instead found that the government interest was strengthened by the general benefits of punishment.

In sum, courts tend to find the government interest at stake is important in the majority of cases, but give little consideration to the defendant's particular circumstances. The facts of the individual case, which should be the primary bulwark between a defendant and medication, have been brushed aside in favor of a single-minded focus on medication dosages and treatment plans—an analysis that rarely supports anything other than a medication order. The result: a multitude of defendants who have been medicated against their will, many of whom end up confined in prison for years before they even can be brought to trial.

## IV. FOCUSING ON THE FACTS OF THE INDIVIDUAL CASE

By emphasizing the impact of individual circumstances on the government interest, courts would involuntarily medicate fewer defendants and more clearly identify those exceptional cases where medication for the sole purpose of prosecuting a defendant is warranted. Although several courts have already incorporated

184. United States v. Kimball, No. CR03-1025, 2004 WL 3105948, at *1–2 (N.D. Iowa Mar. 23, 2004).
185. *Id.* at *3.
186. United States v. Bush, 585 F.3d 806, 814–15 (4th Cir. 2009).
187. *Id.* at 815.

individual circumstances into their *Sell* analyses, many mistakenly place this consideration into their discussion of medication efficacy and side effects, rather than their assessment of the government interest.

*Evans* provides one such example. In *Evans*, the Fourth Circuit chided the lower court for failing to treat the defendant as an individual. However, the court only considered the defendant's individual circumstances when analyzing the medication's efficacy and side effects, not the strength of the government interest. In its analysis, the court cautioned against accepting the generalized rationales that psychiatrists had provided in other cases:

> Instead of analyzing Evans as an individual, the [psychiatrist's] report simply sets up syllogisms to explain its conclusions: (1) atypical antipsychotic medications are generally effective, produce few side effects, and are medically appropriate, (2) Evans will be given atypical antipsychotic medications, (3) therefore, atypical antipsychotic medication will be effective, produce few side effects, and be medically appropriate for Evans. To hold that this type of analysis satisfies *Sell*'s second and fourth factors would be to find the government necessarily meets its burden in every case it wishes to use atypical antipsychotic medication. We do not believe that *Sell*'s analysis permits such deference.[188]

While the *Evans* court was correct that such blanket generalities are insufficient to satisfy *Sell*, it failed to recognize that courts would always rely on some level of generality when assessing the impact of a medication on individual defendants because individual reactions are impossible to gauge in advance. Since generalities will always be a part of the analysis of the second and fourth factors, the proper place for the assessment of a defendant "as an individual" is instead with the government interest factor. A consideration of the facts of the individual case—including the nature of the individual's crime—would help courts identify those cases where the government interest is not just "important," but important enough to justify medication.

The Fourth Circuit's later decision in *United States v. White* adopted this approach in its analysis of the government interest factor.[189] Defendant Kimberly White stood accused of six felonies involving credit card fraud and aggravated identity theft.[190] White's co-defendant pled guilty to three counts, and the court sentenced her to thirty-six months in prison.[191] Psychiatrists diagnosed White with delusional disorder, grandiose type, and the court found that she was incompetent to stand trial.[192] After a *Sell* hearing, the court ordered that White be medicated

188. United States v. Evans, 404 F.3d 227, 241 (4th Cir. 2005).
189. United States v. White, 620 F.3d 401, 404–05 (4th Cir. 2010).
190. *Id.* at 405.
191. *Id.* at 415–16.
192. *Id.* at 405.

against her will.[193] The Fourth Circuit reversed that order. Focusing only on the first *Sell* factor, the court found that "special circumstances," such as the three years White had already been incarcerated, sufficiently undermined the government interest in bringing White to trial.[194] In addition to this usual consideration of length of incarceration as a special circumstance, the court also took into account factors not explicitly stated in *Sell*, including (1) the nature of White's crime, (2) the lack of public safety concerns, and (3) the unexceptional nature of the case.[195]

First, the court noted while the alleged crimes were technically "serious," their severity was low relative to other crimes.[196] For example, the alleged crimes were non-violent, which lessened the government's prosecutorial interest.[197] The victims of the credit-card fraud were also corporations, so prosecution would not provide restitution or any "conceivable benefit" to the corporate victims.[198] Further, no individuals were harmed, and there was no evidence that White was likely to commit future crimes of violence.[199] The relative lack of present and future harm was sufficient to distinguish White's crimes from those of the defendant in *Bush*, who was accused of threatening a federal judge, a crime that contained the possibility of future violence.[200]

Second, the court found public safety concerns in this case were significantly diminished because, as someone who has been adjudicated as mentally defective, the defendant could never obtain or own a firearm under federal law.[201] A conviction was therefore unnecessary "insofar as it would safeguard the public from any possible acts of gun violence from her."[202] Again, this factor distinguished *White* from *Bush*, where, given the defendant's potentially violent activities (threatening a federal judge), prosecution was justified in order to limit the defendant's subsequent activities under her supervised release program, including the ability to obtain and own firearms.[203]

Third, the court conducted a more general totality of the circumstances-type analysis to determine whether the circumstances of the case, taken as a whole,

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193. *Id.* at 409.
194. *Id.* at 413.
195. *Id.*
196. *Id.* at 419.
197. *Id.*
198. *Id.*
199. *Id.*
200. The court principally uses this line of argument to distinguish *White* from *Bush* and *Evans*, in which the court found the first *Sell* factor was met, even though the defendants in those cases would probably exceed their likely sentence by the time they were convicted (like White). *See id.* ("The non-violent nature of White's crimes principally distinguishes this case from *Bush* and *Evans*.").
201. *Id.* at 419–20.
202. *Id.* at 420.
203. The court does not explain why, under federal law, Bush would be allowed to own firearm and White would not when both women had been adjudicated as mentally defective.

were "sufficiently exceptional" to warrant forcible medication.[204] The court found that they were not:

> White is a non-violent detainee who has served more than the entirety of her likely sentence in pre-trial detention, and in onerous conditions at that. The alleged victims of her crimes, which were solely property crimes, would not likely benefit or be made whole in any way by her prosecution. She is neither a danger to herself nor to the public, nor will she ever be able to purchase a gun.[205]

Given these findings, the court concluded the government interest in prosecuting this serious crime was outweighed by special circumstances. Importantly, the court tried to draw a line differentiating routine cases from sufficiently exceptional ones. White was an "all-too-common, non-violent, long-detained defendant," not a danger to society, and her victims would not be made whole if she were convicted.[206] Medicating a defendant like White "would risk making 'routine' the kind of drastic resort to forced medication for restoring competency that the Supreme Court gave no hint of approving in *Sell*."[207] Her case therefore was not sufficiently exceptional to warrant forcible medication.

The *White* approach places the emphasis in the *Sell* test where it belongs, with the individual circumstances of the case. It also opens the door to consideration of additional facets of an individual's circumstance, particularly those cases where the defendant's crime appears intimately connected to his mental illness. A defendant whose alleged crimes reflect nothing more than the nonsensical wanderings of a troubled mind may well fall on the less important side of the spectrum.

Several courts have already refused to medicate defendants when the crimes seem to be a manifestation of their mental illness. In *United States v. Weinberg*, for example, the Western District of New York found Weinberg's threatening a judicial officer to be "quite consistent with Weinberg's illness," and the fact that he sent the threats to government officials and the FBI "suggests that his actual intent to commit the act was delusional as well."[208] The court held the government's interest in prosecuting this crime was not important.

The circumstances in *United States v. Lindauer* were even more extreme. In *Lindauer*, the defendant believed she was a back door channel between the United States and Iraq for events in the Middle East. She was then charged with acting as an unregistered agent of the Iraqi government and engaging in forbidden financial transactions with Iraq.[209] The court found important government interests were not

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204. *Id.* at 421.
205. *Id.* at 421–22.
206. *Id.*
207. *Id.* at 422.
208. 743 F. Supp. 2d 234, 237 (W.D.N.Y. 2010).
209. 448 F. Supp. 2d 558, 560, 562 (S.D.N.Y. 2006).

at stake because it could not prove an essential element of the crime—that the defendant had influenced people: "The indictment charges only what it describes as an unsuccessful attempt to influence an unnamed government official, and the record shows that even lay people recognize that she is seriously disturbed."[210]

Thus, when confronted with the facts of the individual case—that the defendant was seriously mentally disturbed and her actions were directly related to that disturbance—in cases where there was no physical harm to property or individuals, some courts have found that the government interest at stake does not rise to a level that justifies medication. More courts can and should follow this path.

A renewed emphasis on the facts of the individual case is, of course, not the only solution to the problem of overmedication in the years following *Sell*. For example, one scholar noted an analysis more similar to the balancing test conducted for Fourth Amendment inquiries would better protect incompetent defendants from unreasonable harms imposed by involuntary medication.[211] Under this approach, courts would abandon the categorical thresholds imposed by the *Sell* test in favor of an inquiry that weighs the defendant's interest in avoiding the harms of involuntary medication directly against the government's interest in rendering the defendant competent to stand trial.[212]

While this approach would more accurately mirror the test set out for other due process claims, and would also succeed in circumscribing the number of defendants involuntarily medicated to those rare cases in which it is warranted, it would require Supreme Court intervention—and reversal of its precedent—to implement. The Court has given no indication that it desires to wade back into the involuntary medication waters. The proposal in this Article, by contrast, recognizes that the seeds for a solution to the overmedication problem rest in the test itself and its requirement that courts consider the facts of the individual case when conducting an involuntary medication inquiry.

## V. CONCLUSION

Herbert J. Evans was incarcerated for four years before two separate juries found him not guilty of either threatening a federal judge or assaulting a federal employee.[213] In that lengthy time between the day when he first entered the USDA office and his acquittal, two different federal district court judges assessed his case. One decided that the government interest in prosecuting him for assault on a federal employee was not sufficiently important to warrant medication, while the other decided that his later crime of threatening a federal judge cleared that bar.[214]

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210. *Id.* at 572.

211. Klein, *supra* note 178, at 205.

212. *Id.*

213. United States v. White, 620 F.3d 401, 418 (4th Cir. 2010).

214. United States v. Evans, No. 102CR00136, 2004 WL 533473, at *2 (W.D. Va. Mar. 18, 2004); United States v. Evans, 293 F. Supp. 2d 668, 674 (W.D. Va. 2003).

His case went up to the Fourth Circuit twice: the first time, the lower court insufficiently laid out the plan for medication, but on the second trip, a more detailed medication plan was given the stamp of approval.[215] Despite concerns about treating Evans "as an individual," the court never looked to the facts of his individual case, such as his long history of mental illness or the likely connection between his mental illness and his alleged crime. Had the court done so, it may have found that Evans's case was not sufficiently exceptional to warrant medication, saving Evans from four years of imprisonment and multiple injections of unwanted medication. It also could have avoided the waste of government resources that accompanied such a lengthy prosecution with no resulting conviction.

The place for such considerations is within the analysis of the government interest factor. It is here that the Supreme Court incorporated a robust inquiry into the circumstances of the case that could potentially undermine the importance of the interest at stake. Yet, extensive analyses of this factor are missing from many court decisions in lieu of lengthy discussions of medication specifics. Overmedication of defendants who are "all-too-common, non-violent, [and] long-detained" is the result.[216]

To solve this problem, courts must analyze the individual facts of a case under the government interest factor to identify the sufficiently exceptional cases that warrant medication. *Sell* provided an avenue for courts to deeply consider a defendant's individual right to be free from the physical and psychological intrusion of antipsychotic medications. Widespread adoption of an individualized approach, the approach that *Sell* intended, would turn involuntary medication of defendants from almost routine—as it is now—into the "rare" circumstance envisioned by the Supreme Court.

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215. United States v. Evans, 199 F. App'x 290 (4th Cir. 2006); United States v. Evans, 404 F.3d 227 (4th Cir. 2005).

216. *White*, 620 F.3d at 421–22.