

2006

## Utah v. William Eileen Barzee : Reply Brief

Utah Court of Appeals

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**IN THE UTAH SUPREME COURT**

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STATE OF UTAH,  
Plaintiff/Appellee,

vs.

WANDA EILEEN BARZEE,  
Defendant/Appellant.

Case No. 20060627-SC

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**REPLY BRIEF OF APPELLANT**

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**INTERLOCUTORY APPEAL FROM DISTRICT COURT'S RULING GRANTING THE STATE'S MOTION TO COMPEL MEDICATION, IN THE THIRD JUDICIAL DISTRICT COURT IN AND FOR SALT LAKE COUNTY, STATE OF UTAH, THE HONORABLE JUDITH S. ATHERTON PRESIDING. APPELLANT IS CURRENTLY BEING HELD IN THE FORENSIC UNIT OF THE UTAH STATE HOSPITAL, PROVO.**

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**PUBLISHED OPINION REQUESTED**

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**IN THE UTAH SUPREME COURT**

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**REPLY BRIEF OF APPELLANT**

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**SUMMARY OF ARGUMENT**

The State’s “failure to marshal” argument is without merit as it fails to cite any facts not marshaled.

The State has also failed to establish by clear and convincing evidence that forcible medication is substantially likely to further the State’s interest in this case. Many of the facts the State cites in support of its claim that competency restoration is substantially likely while adverse side effects are substantially unlikely, are irrelevant and misleading. The State’s legal analysis similarly misconstrues the cases it relies upon, which cases are mostly irrelevant to Ms. Barzee.

The State also fails to meet its burden under the additional *Sell*<sup>1</sup> factors. In its

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<sup>1</sup>*Sell v. United States*, 539 U.S. 166, 123 S. Ct. 2174, 156 L.Ed. 2d 297 (2003).

analysis of the State's interest in prosecuting Ms. Barzee and contrary to the undisputed evidence on record, the State erroneously assumes that Ms. Barzee is a danger to herself or to others outside the confines of the state hospital. Also, the State presents insufficient evidence to make any conclusion about the likelihood of Ms. Barzee's long-term commitment to a mental health facility, as the trial court noted in its ruling. The State fails to establish by clear and convincing evidence that its interest outweighs Ms. Barzee's liberty interest.

Similarly, the State fails to establish by clear and convincing evidence that there are no less intrusive alternatives to forcible medication, or that it is medically appropriate in Ms. Barzee's case.

Finally, the State's cursory assertion that Ms. Barzee's state constitutional law claim is inadequately briefed is insufficient to rebut Ms. Barzee's argument and analysis on that point, and should therefore be disregarded.

## **ARGUMENT**

### **I. THE STATE'S "FAILURE TO MARSHAL" ARGUMENT IS WITHOUT MERIT AND SHOULD BE SUMMARILY DISREGARDED.**

The State generally asserts throughout its brief that Ms. Barzee has failed to marshal the evidence. This claim is without merit. The State's sweeping assertions of Ms. Barzee's purported failure to marshal are inaccurate, particularly when it fails to cite any unmarshaled facts. *See, e.g.*, BRIEF OF APPELLEE ("Br. Appe.") at 29 ("A comparison of the parties' factual summaries quickly establishes defendant's marshaling

failures regarding Drs. Jeppson's and Whitehead's testimony" (citing pages in both parties' briefs, without more)); *see also, id.* at 35 (asserting, "The marshaled facts negate defendant's claim", without citing any facts not marshaled). The State fails to point to any specific facts not marshaled and further seems to suggest that Ms. Barzee can only meet a marshaling requirement, if any applies, if she skews the facts in the State's favor and thereby makes the State's argument for it. *Id.* at 37.<sup>2</sup>

Moreover, given Ms. Barzee's lengthy and detailed Statement of Facts set forth in her opening brief and created with the marshaling requirement in mind, and as demonstrated by the State's unsupported assertions, the State is hard pressed to find even an obscure fact not marshaled. As a comparison between the record, the parties' briefs and their respective recitations of the facts demonstrates, the only thing Ms. Barzee's opening brief is lacking is the State's argument and its concomitant version of the facts.

The State's "failure to marshal" argument is not only improper, but is so lacking in merit that it serves only to diminish the State's credibility. Accordingly, the State's

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<sup>2</sup>The State argues, "Again, defendant fails to properly marshal the facts. When marshaled, the evidence supports the court's assessments." Then in the following paragraph the State recounts some of the trial court's findings and the testimonies of Drs. Jeppson and Whitehead, all of which are in fact marshaled in Ms. Barzee's opening brief, in addition to other relevant facts not acknowledged by the State. *See, e.g.*, BRIEF OF APPELLANT ("Br. Appt."), at 15-16, 27, 36-37. This pattern of one-sided and unsupported assertions is followed throughout the State's brief. However, unlike Ms. Barzee who has assumed the significant marshaling burden applies, the State tends to ignore those facts unfavorable to its position, thereby facilitating the State's ability to create a one-sided and thus inaccurate view of the evidence in this case.

claim that Ms. Barzee failed to marshal the evidence should be summarily disregarded.

**II. THE EVIDENCE FAILS TO ESTABLISH A SUBSTANTIAL LIKELIHOOD OF MS. BARZEE BEING RESTORED TO COMPETENCY THROUGH FORCED MEDICATION, OR A SUBSTANTIAL UNLIKELIHOOD OF ADVERSE SIDE EFFECTS.**

The State's burden to establish by clear and convincing evidence that involuntary medication is substantially likely to further the State's interest in this case is certainly formidable. The law and the evidence the State cites in its efforts to meet that burden is sometimes irrelevant and mischaracterized, and in some cases actually supports Ms. Barzee's position. While the evidence is lengthy and detailed, the legal and factual analysis is not complicated.

**A. THE STATE'S FACTUAL ANALYSIS IS MISLEADING.**

The trial court deferred to Dr. Jeppson in granting the State's motion to compel medication. R557-58. Therefore, the analysis hinges really upon one question: Did the State establish by clear and convincing evidence that Dr. Jeppson's inexperienced but "hopeful" "wait and see" (R579:14, 18-20, 30-1, 45) approach is substantially likely to render Ms. Barzee competent, and substantially unlikely to result in side effects impairing her ability to consult with her attorneys? *See, United States v. Dallas*, 2006 U.S. Dist. LEXIS 81162 (D. Neb. May 11, 2006) (rejecting a similarly vague treatment regimen as insufficient under *Sell* to establish a substantial likelihood of competency restoration).

In other words, is "practicing [] an N of 1" and "see[ing] if she responds or not" (R579:45) clear and convincing evidence of a *substantial likelihood* that Dr. Jeppson's

approach will not just be beneficial, but will actually restore Ms. Barzee to competency?

It is not, and the State cannot meet its burden on these facts. Accordingly, the State seeks to avoid this problem with its own evidence by focusing on facts that are irrelevant or misleading.

For example, the State claims in its Statement of Facts that Dr. Jeppson experienced a 70-80 percent success rate in restoring “his psychotic delusional patients” to competency. Br. Appe. at 14.<sup>3</sup> This mischaracterizes Dr. Jeppson’s testimony. He opined that there was a 70-80 percent restoration rate among general populations of patients at the federal hospital in St. Louis and “some of the other districts have reported 70 percent. . . . [W]e have those kinds of numbers at our hospital.” R579:32. Dr. Jeppson also testified that this rate was equivalent to the rate of restoration in patients suffering from psychotic disorder NOS, his newly derived diagnosis of Ms. Barzee. *Id.* Dr.

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<sup>3</sup>In a footnote, the State argues, “Contrary to defendant’s suggestion that [Dr. Jeppson’s] death impacts the trial court’s ruling, it was known prior to the medication hearing that the doctor was seriously ill, yet defendant never claimed the court should consider this fact in ruling” (citations omitted). This argument is both inappropriate, because it is not supported by the record, and untrue. The defense was never apprised by the State of Dr. Jeppson’s illness and was shocked to learn of his death from the obituary section of a local newspaper, coincidentally on the same day the trial court issued its ruling in this case. The State’s suggestion that the defense had an obligation to raise the possibility of Dr. Jeppson’s death in the trial court is also either disingenuous or reflects a lack of understanding. Although the trial court improperly made Dr. Jeppson’s death relevant when it deferred solely to him because of his supposed familiarity with Ms. Barzee rather than pointing to objective facts supporting a substantial likelihood of competency restoration (R558-59), neither Dr. Jeppson’s purported familiarity nor his untimely death are relevant under *Sell*. Therefore, it would have been improper for the defense to ask the court to consider the impact of Dr. Jeppson’s pending death.



Jeppson said nothing about “his” “psychotic delusional patients.” Br. Appe. at 14.

The State also suggests it is significant that Dr. Raphael Morris did not read all of Ms. Barzee’s hospital records. Br. Appe. at 18, 38.<sup>4</sup> If this is significant, then it should also be noted that neither Dr. Jeppson nor Dr. Whitehead testified that they had read all of Ms. Barzee’s hospital records. R579. It is not even clear what Ms. Barzee’s “full hospital file” (Br. Appe. at 18) is comprised of, much less that her treating physician reviewed it in its entirety. However, this is a non-issue and irrelevant to Dr. Morris’ credibility and expertise. He was retained as an expert on the efficacy of antipsychotic medications on someone exhibiting Ms. Barzee’s undisputed symptoms and history as reported by other experts. His incidental meeting with Ms. Barzee prior to the evidentiary hearing was merely fortuitous but not necessary. Nonetheless, as a result of that meeting, Dr. Morris has had as much contact with Ms. Barzee as Dr. Whitehead has. R579:59-60, 101.

The State further quotes Dr. Xavier Amador’s testimony that if there was only a 5 percent chance of competency restoration, he would “do everything in [his] power to convince a patient to take medication . . . Untreated psychosis is a bad thing.” Br. Appe. at 24; R579:186. This testimony is irrelevant to the second prong of *Sell*. The fact that every doctor who testified, and presumably any doctor, would treat a patient if there was even a

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<sup>4</sup>The State also implies that Dr. Amador did not read Ms. Barzee’s medical records. Br. Appe. at 38. There is no evidence to suggest Dr. Amador did not read Ms. Barzee’s full file. Moreover, he testified that prior to one of his interviews with Ms. Barzee, he “had reviewed a substantial number of hospital records already.” R579:182.

slim hope of some beneficial effect, has no bearing on the question of whether such treatment is substantially likely to result in competency restoration. It is certainly not clear and convincing evidence.<sup>5</sup> Moreover, beneficial effect, either physical or psychological, does not equate to competency restoration, yet the State seems to suggest they are one and the same.

The State's additional claim that "All the doctors . . . agree that unless defendant is medicated, she will remain incompetent" (Br. Appe. at 26), is also a mischaracterization, at least by omission. The State's later assertion that Dr. Amador "agreed that only medication could possibly accomplish" (Br. Appe. at 42) competency restoration is similarly a misstatement of the evidence, as can be observed by reviewing the record cited by the State (R579:166-67, 175-76, 187, 191) (**Addendum A**). Neither Dr. Morris nor Dr. Amador testified that Ms. Barzee could become competent only through medication, and the State omits mentioning that neither doctor believes Ms. Barzee will be restored to competency via medication or any other means. R579:107-08, 115-16, 117-18, 122, 123, 128, 137, 145, 160-61, 162, 163-64, 166-69, 171-76, 177, 191.

The State also claims that Ms. Barzee ignored the fact that both Drs. Morris and

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<sup>5</sup>The State makes a puzzling conclusion in its footnote 13 (Br. Appe. at 25). It compares Ms. Barzee's purported reluctant willingness to take medication solely to please hospital staff to Dr. Amador's proposed use of persuasive therapy to convince her it is in her best interest to do so. The State concludes, "Unlike Dr. Amador, Dr. Whitehead did not view this as consent." (Citations omitted). Notwithstanding the fact that these two situations are hardly similar, the State's conclusion is completely irrelevant.

Amador would treat her with medication. Br. Appe. at 39. However, notwithstanding the fact that Ms. Barzee did not ignore the substance of her own experts' testimony in this context (*see*, Br. Appt. at 22, 26), it is completely irrelevant to the question of whether there is a substantial likelihood that forcible medication will render Ms. Barzee competent.

Similarly, the State's claim that Ms. Barzee ignored the "salient" fact that "no expert claimed that the anticipated side effects would significantly interfere with her ability to consult with her attorneys" (Br. Appe. at 39) evades the State's high burden to establish by clear and convincing evidence that such interfering side effects are substantially unlikely. It also ignores Dr. Amador's singularly expert testimony that forcible medication would likely result in traumatic side effects of a nature that would presumably interfere with Ms. Barzee's ability to consult with counsel. R579:187, 190-93. General assertions by the State's witnesses that serious side effects are rare and Ms. Barzee would be monitored for the same (R579:21, 46-8, 55-6, 65-6, 199-200) are insufficient. Even the State acknowledges that the medications proposed in this case are a "new generation" (Br. Appe. at 40), and as is the nature of all newer drugs, side effects are emerging and thus not all known at this early stage.

The State further notes, "[D]efendant argues why the trial court *could* have accorded more weight to the defense opinions, but does not establish why the court's failure to do so is clear error." Br. Appe. at 29 (emphasis in original). Ms. Barzee has never taken the position that the trial *could* have ruled in her favor; rather, her position is

that the trial court *should* have done so because the clear weight of the evidence is overwhelmingly in her favor. Br. Appt. 29-50. The trial court ignored the scientific research contrary to the government's position and deferred to the one witness in this entire case who admitted he was not an expert; and as the primary physician charged with the responsibility of restoring Ms. Barzee to competency, he had what he apparently construed as a professional stake in persuading the trial court to compel medication. R558-59; R579:11, 14, 26, 28, 30-1. This evidence falls far short of the State's burden to prove by clear and convincing evidence a substantial likelihood of restoration.<sup>6</sup>

The State fails to disclose other facts unfavorable to its position. Noting that delusional disorder is rare, the State claims that only Dr. Amador reached that diagnosis. Br. Appe. at 35. The State fails to acknowledge the history of multiple diagnoses in Ms. Barzee's case, and more importantly, the fact that all experts have agreed that her delusional symptoms are most prominent and have remained constant.<sup>7</sup> See, e.g., R336-

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<sup>6</sup>The State attempts to bolster its evidence and the trial court's ruling by asserting, without any citation to the record, that "the trial court observed and interacted with defendant during numerous court proceedings over two years." Br. Appe. at 34. Not only is this statement not supported by the record and therefore inappropriate, but there is no aspect of the ruling that even suggests the court employed any such considerations.

<sup>7</sup>The State notes Dr. Amador had not seen Ms. Barzee for about a year prior to the hearing (Br. Appe. at 38), but fails to explain why this is significant, particularly when none of her symptoms had changed and the hospital treatment team had also not seen her for about the same amount of time. R579:18. Also, Dr. Jeppson left on medical leave for two and a half months shortly after the State filed its motion during the Fall of 2005, and there is no evidence to suggest that the duration or quality of his contact with Ms. Barzee exceeded or even met that of Dr. Amador. R579:12.

37; R577:19-20, 25, 33, 37-8, 47, 52, 55, 72-3; R578:10-11, 14-16, 18, 23; R579:12, 14-15, 18-19, 41-2, 77-8, 103, 118, 130, 154, 165, 167-69, 171-73, 191, 193-94.

Drs. Cohn and Kovnick initially reached separate diagnoses of schizophrenia and shared psychotic delusional disorder, respectively, while noting that Ms. Barzee suffers from delusions. R336-37. Dr. Berge agreed with Dr. Kovnick in reaching his diagnosis of shared psychotic delusional disorder but stated he would change the diagnosis to delusional disorder if Ms. Barzee's delusions continued after her separation from the co-defendant, which they have. R577:19-20, 52. In the meantime, Dr. Jeppson, Ms. Barzee's "default" treating physician, also diagnosed her with delusional disorder. R579:12.

Although Ms. Barzee's delusions continued, coinciding with the hospital's and the State's efforts to force medicate Ms. Barzee and in anticipation of a *Sell* hearing, Dr. Jeppson for the first time changed to the "working" and less specific diagnosis of psychotic disorder NOS. R579:12, 33, 38-41. Dr. Nielson concurrently reached the same diagnosis. R578:10-12, 19-20. The State has little to no response to the fact that both Dr. Morris and Dr. Amador, who are irrefutably the most highly qualified experts on the subject, pointed out that a diagnosis of psychotic disorder NOS is based on a lack of information, and is therefore questionable after the hospital has had two years to observe Ms. Barzee and thereby reach a narrower diagnosis. R579:128-29, 132-33, 154-55. And contrary to the State's representation of the facts (Br. Appe. at 35), although he had formed an informal opinion, Dr. Morris did not make a formal diagnosis of Ms. Barzee

and was not retained to do so. R579:130.

Finally, Dr. Amador, presumably the final word on the subject since he actually revised the relevant portions of the very manual all experts agree they should have relied upon in reaching their diagnoses, concluded that Ms. Barzee suffers from delusional disorder. R579:152, 154, 164. Notably, the State fails to acknowledge that Dr. Amador reached this diagnosis from the beginning of his contact with Ms. Barzee two years prior to his testimony and at a time when a *Sell* hearing was not even anticipated. R579:164.

On a related note, the State claims, “While the state doctors opined that labels were less important than symptoms, Drs. Amador and Morris admitted that even if her symptoms did not change, what label attached would change their restoration projections (R579:128, 166-67, 175-76, 186).” Br. Appe. at 36. This is not true. A review of the State’s citations to the record is illuminating and are included in **Addendum A**.

On page 128 of the transcript, consistent with the testimony of some of the State’s experts, Dr. Morris discusses how diagnosis impacts the likelihood of restoration. Nowhere does he claim that prognosis is not impacted by symptoms. To the contrary, both Drs. Morris and Amador criticized the State’s witnesses for failing to properly account for Ms. Barzee’s symptoms in forming their diagnoses and conclusions. R579:102-04, 107-08, 115-18, 122-23, 128, 132-33, 137, 145, 154-55, 162-64, 165-67, 171-77, 193-94.

Further on pages 166-67, Dr. Amador explains the unlikelihood of competency restoration in light of Ms. Barzee’ delusional disorder, the duration of her untreated

psychosis, and “the primary competency impairing symptom of grandiose delusions” (R579:166). On pages 175-76, Dr. Amador discusses the negative impact of Ms. Barzee’s lack of insight (i.e., anosognosia, a symptom of delusional disorder) on her prognosis for restoration to competency. He also explains if Ms. Barzee suffered from schizophrenia or psychotic disorder NOS, although anosognosia would still negatively impact prognosis, Ms. Barzee’s chances for restoration would be slightly higher. Finally, on page 186, Dr. Amador explains that he would do everything in his power to treat a psychotically ill patient even if there was only a 5 percent chance of beneficial effect. A specific diagnosis is not even mentioned.

Based on the foregoing, the State’s characterization of this cited testimony as an admission that Drs. Morris and Amador would not change their prognosis for restoration even if Ms. Barzee’s symptoms were to change, is misleading. Their respective testimonies are all about how Ms. Barzee’s symptoms negatively impact her prognosis.

The State also cites pages 311, 328 and 343 of the DSMV-IV<sup>8</sup> as supporting authority for the State’s claim that “a [psychotic disorder NOS] diagnosis remains valid as long as symptoms of two or more psychoses exists.” Br. Appe. at 36 and its *Addendum E*.<sup>9</sup> The citations given do not support the State’s conclusion. Page 311 is missing from Ms. Barzee’s copies of the State’s brief. Page 328 states:

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<sup>8</sup>*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition.

<sup>9</sup>The State’s reliance on the DSMV-IV seems ironic given that Dr. Jeppson, the doctor deferred to by the trial court, does not rely upon it much. R579:31, 35, 54.

A diagnosis of **Psychotic Disorder Not Otherwise Specified** may be made *if insufficient information is available* to choose between Delusional Disorder and other Psychotic Disorders or to determine whether the presenting symptoms are substance induced or the result of a general medical condition.

(Bold in original; emphasis added). Page 343 states in pertinent part:

This category [of psychotic disorder NOS] includes psychotic symptomatology (i.e., delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior) *about which there is inadequate information to make a specific diagnosis or about which there is contradictory information*, or disorders with psychotic symptoms that do not meet the criteria for any specific Psychotic Disorder.

(Emphasis added) (Br. Appe. *Addendum E*).

There is nothing in this language to suggest that a diagnosis of psychotic disorder NOS “remains valid as long as symptoms of two or more psychoses exists.” Br. Appe. at 36. Rather, it is consistent with both Dr. Morris’ and Dr. Amador’s testimony that it is generally a temporary diagnosis based upon a lack of information (R579:102-04, 128-29, 132-33, 154-56), and is therefore not appropriate after two years of observation and after Ms. Barzee has already been diagnosed several times with more narrow diagnoses.

Moreover, Dr. Jeppson’s stated reason for changing the diagnosis from the refractory delusional disorder was his purported observation of referential thinking, which he admitted Ms. Barzee had exhibited when he first diagnosed her with delusional disorder (R579:12, 22, 41), and which he characterized as atypical of that diagnosis.<sup>10</sup> R579:33.

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<sup>10</sup>Dr. Whitehead did not diagnose Ms. Barzee. However, while he found the “broad umbrella” diagnosis of psychotic disorder NOS reasonable given the “limitations of assessment”, he agreed that a diagnosis of delusional disorder is also reasonable.



However, the DSMV-IV specifically notes that this type of thinking is in fact symptomatic of delusional disorder:

Ideas of reference (e.g., that random events are of special significance) are common in individuals with this [delusional] disorder. Their interpretation of these events is usually consistent with the content of their delusional beliefs.

Br. Appe. *Addendum E* at 325-26.

Even to a layman, Ms. Barzee's belief that God gives her messages through movies is consistent with the content of her grandiose religious delusions that she is the mother of Zion and a prophet. That Dr. Jeppson was unaware that this behavior is symptomatic of delusional disorder may be attributed to his status as a "clinician" rather than as an expert, he did not "pack around" the diagnostic manual relied upon by professionals in his field, nor had he read it recently. R579:31, 35, 54.

The State's desired interpretation of the facts in this case does not change them. Nor do the irrelevant facts cited help the State in meeting its significant burden in establishing a substantial likelihood of restoration via involuntary medication. Also, the State hardly mentions the likelihood or the possible impact of side effects, other than to mention that Drs. Jeppson, Whitehead, and Morris testified such effects are mostly mild and those considered more serious are controllable. Br. Appe. at 34.

While this characterization of the evidence misconstrues Dr. Morris' testimony

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R579:61-2, 76-8. However, Dr. Whitehead is the only expert who believes Ms. Barzee's diagnosis is irrelevant to her prognosis. R579:62, 80.

that the risks associated with medication outweigh the benefits in this case (R579:123-26), it also ignores two important facts that defeat the State's ability to meet its burden: (1) Drs. Jeppson and Whitehead lacked the requisite expertise to account for Ms. Barzee's characteristics, symptoms, and history in reaching their general conclusions; and (2) Dr. Amador, who indisputably has the requisite knowledge and expertise to testify regarding the traumatic side effects observed in patients similar to Ms. Barzee, testified that such effects are likely. R579:187, 190-93. This testimony was not refuted.

The State has failed to establish by clear and convincing evidence a substantial likelihood that involuntary medication will restore Ms. Barzee to competency, or a substantial unlikelihood of side effects interfering with her ability to consult with counsel.

**B. THE STATE'S LEGAL ANALYSIS IS ALSO INCORRECT.**

In addition to the fundamental problems with the State's version of the facts, *supra*, the State's legal analysis is similarly flawed. The State cites several cases in support of its claim that forcible medication is substantially likely to render Ms. Barzee competent. A review of that analysis demonstrates that the State's reliance upon these cases is both misplaced and misleading.

The State cites *United States v. Weston*<sup>11</sup> in support of its claim that forcible medication is substantially likely to render Ms. Barzee competent and substantially

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<sup>11</sup>255 F.3d 873 (D.C. Cir. 2001), *cert. denied*, 534 U.S. 1067 (2001) (**Addendum B**).

unlikely to result in adverse side effects. Br. Appe. at 31, 38, 40. However, *Weston* is largely irrelevant because it predates *Sell* and does not address whether medication was likely to restore competency in that case. Further, *Weston* was schizophrenic and a danger to himself and others such that the court found that his “liberty interest” “gives way when medication is essential to mitigate the detainee’s dangerousness.” *Id.* at 874-75, 876-78. *See also, Washington v. Harper*, 494 U.S. 210 (1990) (allowing involuntary medication if a detainee is a danger to himself and treatment is in his best medical interest). Therefore, the court in *Weston* only considered the question of involuntary medication in the *Harper* context of whether it was medically appropriate and “necessary to accomplish an essential state policy” (*Id.* at 887). The question of the likelihood of restoration was not at issue. Therefore, *Weston* has no relevance to the question of whether forcible medication is substantially likely to render Ms. Barzee competent.

The State also places great weight on the vaguely referenced (R579:32) USMC statistics of a 70-80 percent restoration rate among general populations of psychotic patients. The State cites a number of mostly obscure cases as support for its claim that “other courts have accepted the validity of [general statistics from the U.S. Medical Centers in Springfield and Butner] in ordering involuntary medication of psychotic patients.” Br. Appe. at 38. This claim is not true.

In *United States v. Morris*, 2005 WL 348306, 2005 U.S. Dist. LEXIS 38791 (D. Del. Feb. 8, 2005) (Br. Appe. *Addendum G*), the court did not rely upon the USMC

statistics in reaching its determination that involuntary medication was substantially likely to render Morris competent. Indeed, there is no analysis on that point whatsoever, as the decision is substantively an order compelling medication and the court merely concludes that the government met its burden. *Id.*

The State similarly misconstrues the additional cases it cites. Br. Appe. 38-9. *See, United States v. Archuleta*, 2006 WL 2476070, 2006 U.S. Dist. LEXIS 63526 (D. Utah Aug. 24, 2006) (Br. Appe. *Addendum G*) (same); *United States v. Ballestros*, 2006 WL 224437, 2006 U.S. Dist. LEXIS 6011 (E.D. Cal. Jan. 25, 2006) (Br. Appe. *Addendum G*) (no mention of USMC studies and court merely concludes based on expert's testimony outlining treatment regimen that restoration of competency is substantially likely); *United States v. Martin*, 2005 WL 1895110, 2005 U.S. Dist. LEXIS 16477 (W.D. Va. Aug. 10, 2005) (Br. Appe. *Addendum G*) (the court relies solely on the forensic report, not any statistics, and the decision is devoid of any legal analysis on the likelihood of competency restoration and the unlikelihood of side effects); *United States v. Kimball*, 2004 WL 3105948, 2004 U.S. Dist. LEXIS 26586 (N.D. Iowa March 23, 2004 (same<sup>12</sup>; Br. Appe. *Addendum G*)). The most that can be said about these cases is that the defendants were

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<sup>12</sup>The extent of the court's analysis is as follows: "Dr. Evans . . . opined that psychotropic medication is the treatment of choice for the defendant to restore her to competency. [He] further opined that there is a substantial probability that such treatment will result in the restoration of defendant's competence. Dr. Pederson likewise opined that the only course of treatment likely to effectively treat the defendant's condition is antipsychotic medication. The court thus finds that the administration of medication is substantially likely to render the defendant competent to stand trial."

treated at USMCs, which is no surprise since these are all federal cases.<sup>13</sup>

The State's reliance on *United States v. Evans*, 427 F. Supp. 2d 696 (U.S. Dist. Ct. W. Va. 2006) (**Addendum C**) is similarly misplaced. Evans was diagnosed with paranoid schizophrenia and the empirical studies relied upon in predicting his restorability via medication "indicat[ed] a substantial success rate . . . *for patients like Evans*." *Id.* (emphasis added).<sup>14</sup> Similarly, in *United States v. Algere*, 396 F. Supp. 2d 734 (E.D. La. 2005) (**Addendum D**), the government's experts opined "a 70-80% success rate of restoring" all patients, many of them schizophrenic as was Algere, and further cited a separate empirical study demonstrating an 87 percent restoration rate in a group of patients, "most of whom were schizophrenic" as well as studies cited in a practice guideline published by the American Psychiatric Association relevant to Algere's symptoms and diagnosis. *Id.* at 742.

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<sup>13</sup>The State implies that medication will be successful in Ms. Barzee's case when it cites *United States v. Ghane*, 2006 WL 3160691, 2006 U.S. Dist. LEXIS 79421 (W.D. Mo. July 12, 2006) (Br. Appe. *Addendum G*), noting that Ghane became competent when he took medication, "but when his medication was stopped, again lost his competency." Br. Appe. at 33, n. 15. However, a review of the order in *Ghane* evidences that medication was not effective and caused negative side effects. Although Ghane took medication voluntarily, "his perception of events around him is still filtered through his delusions and negatively impacts his ability . . . to participate meaningfully in his own defense." *Id.*

<sup>14</sup>The State claims Ms. Barzee "does not acknowledge that after Evans' case was remanded, additional evidence, similar to the evidence presented in this case, was presented and involuntary medication order." Br. Appe. 39. This is inaccurate. The *Evans* court found persuasive various studies finding an 80 percent restoration in cases similar to Evans' and Evans' prior history of responding positively to medication. *Id.* at 703-04.

Finally, in *United States v. Bradley*, 417 F.3d 1107 (10<sup>th</sup> Cir. 2005) (**Addendum E**), which is also cited by the State, again there is no mention of the USMC studies and the testifying expert merely outlined his proposed treatment regimen. *Id.* at 1115. Moreover, the *Bradley* court noted that the “record admits of little challenge to the proposition that administration of antipsychotic drugs would substantially aid Bradley’s return to competency. We conclude the Government met its burden . . .” *Id.*<sup>15</sup>

The State’s claim that all of the foregoing cases “accepted the validity” of the general restoration rates reported by the USMC in determining a substantial likelihood of restoration is inaccurate. Most cases merely provide bare conclusions and/or orders with no factual analysis, and those that do provide any analysis are irrelevant to Ms. Barzee’s case. They have no similarity to her history or symptomology. Therefore, the State’s reliance on these cases to support its claim that Ms. Barzee is substantially likely to be rendered competent via forcible administration of medication is disingenuous.

In asserting that the prognosis for competency restoration can be extrapolated from general restoration rates and applied to a specific patient, the State ignores the testimony of one of its own experts, Dr. Paul Whitehead. In discussing the fact that 15 out of 15 patients suffering from psychotic disorder NOS were restored to competency at the Utah State Hospital, Dr. Whitehead cautioned:

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<sup>15</sup>The *Bradley* court also conducted a detailed analysis of the potential side effects, which analysis would not be possible here, based on obviously more extensive evidence presented in *Bradley* that was absent in this case. *Id.* at 743-44.

All 15 were restored, but I wouldn't extrapolate that to mean that there is a 100-percent chance someone with that diagnosis would be restored. I don't do statistics on these types of numbers because it is not research, and research is difficult to do with people who are . . . in a hospital against their will".

R579:63.

The law cited by the State does not support the trial court's findings and conclusions or a substantial likelihood of restoration in Ms. Barzee's case.

**III. THE STATE FAILS TO MEET ITS BURDEN UNDER THE REMAINING SELL FACTORS.**

**A. THE STATE HAS FAILED TO DEMONSTRATE AN IMPORTANT INTEREST OVERRIDING MS. BARZEE'S LIBERTY.<sup>16</sup>**

Ms. Barzee has already conceded that the serious nature of the crimes alleged in this case weigh in the State's favor. Br. Appt. at 42. Delay and concomitant fair trial concerns are an issue in every case. However, any remaining considerations under this factor are in Ms. Barzee's favor and outweigh the State's interest. In any event, the State has not otherwise established the contrary by clear and convincing evidence.

First, the State is mistaken in claiming that "the parties disagree on defendant's inherent dangerousness to herself or others outside the limited confines of the state

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<sup>16</sup>In claiming the State must demonstrate an interest overriding Ms. Barzee's liberty, the State accuses Ms. Barzee of mischaracterizing the proper standard, "which requires clear and convincing evidence that important state interests are at stake in restoring defendant's competency." Br. Appe. at 30 (citation and punctuation omitted). This is a distinction without a difference. *See, e.g., United States v. Weston*, 255 F.3d at 879 (explaining the required showing that "other government interests override a pretrial detainee's liberty interest in refusing antipsychotic medication."

hospital.” Br. Appe. at 31. Not only is this assertion unsupported by any citation to the record, but the record establishes that all experts, including the State’s experts, agree that Ms. Barzee is not a danger to herself or to others in any setting. R579:16-17, 19-21, 27, 52, 60. Second, the State’s evidence leaves the question of Ms. Barzee’s continued commitment to a mental health facility unanswered.

It is not Ms. Barzee’s position only that the trial court “should have considered other ‘special circumstances’ unique” (Br. Appe. at 32) to Ms. Barzee’s case. In addition, it is Ms. Barzee’s position that the State failed to establish by clear and convincing evidence that its interest in bringing Ms. Barzee to trial outweighs her liberty interest to refuse antipsychotic medications. Given the State’s failure to meet this burden and its reliance upon the incorrect assumption that any expert in this case has found Ms. Barzee to be a danger to anyone, the State has failed to meet its burden under this prong.

**B. THE STATE FAILS TO SHOW THAT FORCIBLE MEDICATION IS NECESSARY.**

The crux of the State’s argument on this point is that “no evidence exists that alternate, less intrusive means than involuntary medication are likely to restore [Ms. Barzee’s] competency.” Br. Appe. at 41. Then again and without citing the record, the State erroneously claims that “[e]very doctor who examined defendant opined that only medication can restore her competency.” *Id.* and at 42. This claim misconstrues the evidence in this case. *See*, argument and citations to the record, *supra*. Accordingly, the premise underlying the State’s argument is flawed.



Contrary to the State's argument, what Dr. Amador's testimony about the alternative treatment of motivational enhancement therapy did establish is that there is at least one less intrusive alternative to forcibly medicating Ms. Barzee. The State did not rebut this evidence. Moreover, the fact that Ms. Barzee is resistant to formalized therapy and treatment for a mental illness she does not believe she has does not lead to the State's conclusion that she would be unwilling to talk to a treating professional in a different setting. To the contrary, according to Dr. Amador, that is precisely the value of this alternative therapy because it is designed to treat individuals like Ms. Barzee who exhibit anosognosia. R579:186-87, 190-91. The double value inherent in this treatment modality is that it has both a therapeutic effect and may persuade a patient to voluntarily take medication that may also have some beneficial aspect. If successful, of course this treatment modality would make the issues under *Sell* moot. *Id.*

Therefore, from the record evidence, it is known that at least one less intrusive alternative to forcible medication exists. The State failed to elicit any evidence that this alternative is not a viable treatment for Ms. Barzee. It has never been tried in this case. Therefore, its viability has to be presumed at this juncture and it cannot be concluded that the State met its burden of demonstrating by clear and convincing evidence that no less intrusive alternatives to forcible medication exist.

**C. THE FOURTH *SELL* FACTOR OF MEDICAL APPROPRIATENESS IS SUPERFLUOUS UNLESS CONSIDERED IN THE CONTEXT OF FORCIBLE MEDICATION.**

Ms. Barzee did concede in her Petition that every expert testified that administration of antipsychotic drugs is medically appropriate in her case. However, this is not a preservation problem and, as noted in her opening brief and cited by the State, medical appropriateness will be true with every patient unless there are rare and unforeseen health problems that might be exacerbated by a proposed medication. Presumably in such cases, alternative medications will be found that are medically appropriate. Hence, this factor is meaningless as it will likely always be met.

Nonetheless, the fact that in certain cases such as Ms. Barzee's, *forcible* medication is substantially likely to result in adverse traumatic side effects cannot be ignored when considering whether such treatment is medically appropriate. It is well known that depression, suicidal ideation, paranoia, and post-traumatic-stress disorder have physical as well as emotional ramifications. To argue that it is medically appropriate to force an emotionally fragile patient into a severe depression through involuntary medication merely because she suffers from an illness that a doctor would normally treat with medication is a *non sequitur*.

For this prong of the *Sell* analysis to be relevant and have meaning, the medical appropriateness of involuntary medication must be considered.

**IV. THE STATE HAS FAILED TO DO MORE THAN ASSERT THAT MS. BARZEE'S STATE LAW CLAIM IS INADEQUATELY BRIEFED.**

In just over one page, the State generally asserts that Ms. Barzee's state constitutional law claim is inadequately briefed and unfairly before this Court, without more.<sup>17</sup> Br. Appe. at 45-6. This conclusory argument is insufficient to rebut Ms. Barzee's 6 pages of argument and legal analysis, including the lengthy legal history of the compassionate treatment of the mentally ill in this state, and the exceptional circumstances meriting this Court's consideration of the issue on this appeal.

Accordingly, the State has failed to rebut Ms. Barzee's position and this Court should consider the issues in this case within the context of the due process protections afforded in this state.

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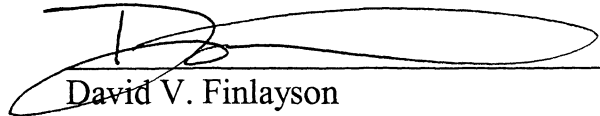
<sup>17</sup>The State makes much of the fact that Ms. Barzee did not cite Utah Code Ann. §77-15-6.5, the state codification of the *Sell* factors. This argument is disingenuous. At the medication hearing, the State indicated on the record:

At the outset, the only other thing that *counsel have raised together . . .* is the standard of proof for the Court to make its decision. *Sell* was silent. We each agree it should be clear and convincing. The Tenth Circuit believes it is clear and convincing, so that's the case law that's applicable to this federal circuit, and *legislation was introduced last week* at the legislature to help these matters in the future, and that legislation provides for a clear and convincing standard. R579:6 (emphasis added). Thus, the statute was pending and only enacted after the medication hearing and after the parties had briefed the issue. The parties could not brief the issues within the context of pending legislation. Also, the trial court framed its findings, conclusions, and ruling in the context of *Sell*, only mentioning the recently enacted statute incidentally. R530-68. In any event, Ms. Barzee's legal analysis does not change under the subsequently enacted statute.

### CONCLUSION

Ms. Barzee respectfully requests this Court to reverse the trial court's ruling granting the State's motion to compel medication.

Respectfully submitted this 5<sup>th</sup> day of December, 2006.

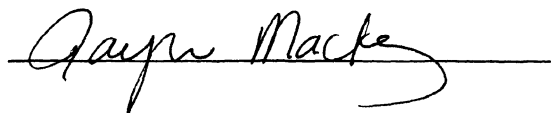


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### **CERTIFICATE OF MAILING**

I hereby certify that on this 5<sup>th</sup> day of December, 2006, I hand-delivered two true and correct copy of the foregoing **REPLY BRIEF OF APPELLANT** to the following:

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# ADDENDA

# ADDENDUM A

**R:579:128, 166-67, 175-76, 186-87, 191**

**(Excerpts from Transcript from Hearing on Motion to Compel Medication)**

1 unlikely she is going to become competent, so that's not more  
2 than likely or even substantially likely, but can you give us a  
3 sense for what the percentage rate is that you think she would  
4 be around, Ms. Barzee, the percentage rate you think you would  
5 attribute to her in becoming competent again?

6       A     I have given this some thought. It is not easy to  
7 give an exact number. It would really also depend on the exact  
8 diagnosis. So I would say, from my experience and also looking  
9 at her prognostic factors, if she had -- and depending on the  
10 diagnosis, it would range somewhere between 20 and 35 percent.  
11 If she had a delusional disorder, which has been discussed  
12 here, I would give her a lower percentage. If she had  
13 schizophrenia, I would give her a better chance of responding.

14       Q     Psychotic disorder is somewhere in the middle there?

15       A     I think we just have to figure out what the diagnosis  
16 is.

17       Q     Everybody is talking about psychotic disorder NOS,  
18 right?

19       A     Right.

20       Q     You run the gamut from delusional disorder to  
21 schizophrenia?

22       A     Psychotic NOS is simply either schizophrenia,  
23 substance abuse psychotic disorder, or psychotic disorder  
24 secondary to a medical condition. It is one of those. I  
25 didn't do a physical exam, but in my assessment I didn't pick

1 treating delusional disorder, but that was primarily with  
2 patients with somatic delusions, not the grandiose type.

3 Q Grandiose delusions are a symptom that could be  
4 associated with delusional disorder or other psychotic  
5 disorders, right?

6 A Yes.

7 Q But those grandiose delusions themselves, of which  
8 everybody agrees Ms. Barzee has and is incompetent because of,  
9 are how difficult to treat? Much more difficult to treat?

10 A I wouldn't say much more difficult. If you look at  
11 the different subtypes of delusions, delusions of jealousy,  
12 somatic delusions, paranoid delusions, grandiose delusions,  
13 etc., if you look at that list, I put that as the hardest to  
14 treat.

15 Q She has the hardest delusion to treat?

16 A Yes. Except I am not talking about a big change in  
17 the prognosis; but within those subtypes of delusions, yes.

18 Q Can you speak a little about her prognosis and the  
19 different factors, indicators? What's her prognosis, in your  
20 opinion?

21 A I think, given the very long duration of untreated  
22 psychosis, given the diagnosis of delusional disorder, given  
23 the primary competency impairing symptom of grandiose  
24 delusions, there is a very low likelihood. Again, you know, as  
25 in the *United States vs. Ghane*, however you pronounce it, the



1 findings of fact there were delusion disorders about a  
2 10-percent chance. I wouldn't go that far. I am a little bit  
3 more optimistic. I would say there is maybe a 20-percent  
4 chance that she will respond to antipsychotic medications to  
5 the point where it will restore her to competency.

6 Q So you are not saying that if she was given  
7 antipsychotic medications that she wouldn't respond in  
8 different ways?

9 A From my clinical assessment, in getting to know  
10 Ms. Barzee as well as I have, both through interview and  
11 collateral sources of information, I have to agree with  
12 Dr. Jeppson, I think the most likely first -- if I had to make  
13 a prediction -- the thing that's going to happen is she is  
14 going to feel less pressure to talk about these things, and  
15 that there is a high likelihood that the fundamental delusional  
16 beliefs aren't going to change.

17 Q So that's a distinction that we have been talking  
18 about here. So she will feel less pressured to talk about  
19 them. So why doesn't that help her back to competency? Or why  
20 doesn't that render her likely to be competent?

21 A Just because I can have a conversation with you about  
22 my case doesn't mean that I have stopped believing that God is  
23 in charge of this whole thing. It doesn't mean that I have  
24 stopped believing. If you still have those beliefs, rather,  
25 given your hypothetical, it is still going to influence your

1 about other topics. If he was talking about flexibility with  
2 respect to her delusional thought process itself, the behaviors  
3 surrounding it, thinking behaviors surrounding it, that's a  
4 different fellow fish. I didn't hear him talk about that.

5 Regardless, we have a very different prognosis on the  
6 likelihood that medications are going to impact her delusion.

7 Q (By Mr. Finlayson) I guess you have explained quite a  
8 bit as to why you have that prognosis. What is your prognosis?  
9 Tell us, on the standard for substantially likely to render her  
10 competent, could you give us your opinion?

11 A Taking together my clinical experience and doing  
12 studies on many, many patients with poor insight, with a  
13 subgroup of very long durations of untreated psychosis, because  
14 of the nature, I have kind of an unusual clinical experience,  
15 compared to a lot of other people, in that I have worked in a  
16 dedicated National Institute of Mental Health funded  
17 schizophrenia research unit. My particular interest is lack of  
18 insight, so the patients we are looking for are a lot like  
19 Ms. Barzee, who do not understand, will take many years to ever  
20 understand there is an illness. Leaning on all that direct  
21 experience and the research, I think you have a very low  
22 probability. My estimate is, if I had to make an estimate, as  
23 you sometimes have to, 20-percent likelihood that any  
24 antipsychotic medication is going to substantially reduce the  
25 severity for delusions to restore her to competency.

1           Q     Would that change if it was psychotic disorder NOS or  
2 schizophrenia?

3           A     No. I think it would move me up a little bit, maybe  
4 give her about a 30-percent chance. If it were schizophrenia  
5 or psychotic disorder NOS, that would move me up. If it was  
6 psychotic manic depression, that would move me up to about 35  
7 to 40 percent. Actually, even higher, because there is less  
8 data on duration of untreated psychosis and bipolar disorder.

9           Q     So the duration is a fairly significant factor, the  
10 grandiose delusions, treating grandiose delusions themselves,  
11 that's a significant factor?

12          A     Yes, both.

13          Q     There was something I wanted to ask you about. It  
14 has been said today it is difficult to do research on people  
15 who don't want to be medicated. Have you been experienced or  
16 read any research on those types of people?

17          A     I have over 100 peer-reviewed articles in the  
18 literature that I have coauthored. I would say half of them  
19 are exactly on this topic. One of my books is called *I'm Not*  
20 *Sick. I Don't Need Help. How to Help Persons with a Serious*  
21 *Mental Illness Accept Treatment*. Half of that book is how to  
22 do involuntarily treatment. It is a step-by-step manual, tells  
23 the reader, whether they are a clinician or family member, how  
24 to do involuntary treatment in all 50 states. A lot of  
25 experience with involuntarily treating and a lot of experience

1           A     Yes.

2           Q     Dr. Amador, isn't it true that nowhere in this book  
3 do you say at a certain point treatment is hopeless?

4           A     I am not saying that here today, either, but you are  
5 right. I am very hopeful about treatment.

6           Q     I believe that there was some testimony from you that  
7 if a person has had a psychotic disorder that has been  
8 untreated for a year their prognosis is going to be very, very  
9 poor?

10          A     Twenty or 30 percent is not hopeless, in my mind.  
11 Frankly, if there was a 5-percent chance I would do everything  
12 in my power to convince a patient to take medication if they  
13 have never been on it, absolutely. Untreated psychosis is a  
14 bad thing. I stand by everything that I have ever said about  
15 that. And that's not the question I have been asked to address  
16 here today.

17          Q     In fact, everything in your book is about getting  
18 these people medication?

19          A     Yes.

20          Q     The mentally ill?

21          A     Absolutely.

22          Q     And there is even chapters that talk about  
23 involuntary commitment?

24          A     Yes.

25          Q     If the mentally ill person has gotten into a state

1 where things are that bad, involuntary commitment is something  
2 you help the reader to assess?

3 A Yes, recognizing the *Harper* criteria, danger to self,  
4 giving them exactly the steps they need to take to  
5 involuntarily -- who to call, how to maintain a relationship  
6 with that person once you have initiated such a proceeding.  
7 There is research on this, as well. It is very traumatic,  
8 oftentimes, to treat people against their will.

9 Q It sounds like it would also be your opinion, as was  
10 Dr. Morris', that it is medically appropriate to give  
11 medication to Ms. Barzee?

12 A In a vacuum, yes. If she were my patient, would you  
13 like me to answer that question? If she were my patient I  
14 would engage her and work with her and use an evidenced-based  
15 practice called motivational enhancement therapy with her,  
16 which I talk about in the book, and try to help her find  
17 reasons that she might want to try a medication. Maybe her  
18 reasons have nothing to do with having a mental illness. It is  
19 a very different approach than the doctor knows best  
20 psychoeducational approach that she is getting in the hospital  
21 here, and most hospitals, frankly, from my reading of the  
22 chart, anyway. So, certainly, as I said a few minutes ago, I  
23 wouldn't give up hope, no.

24 Q And you were talking about what you would do with  
25 Ms. Barzee, and you would engage in motivational enhancement

1 need? If you are going to do that you better be sitting ready.  
2 Again, I think these doctors are ready to do that. But it is  
3 serious business to force medication against somebody's will,  
4 very serious business.

5 Q Yet it is something that with some individuals needs  
6 to be considered?

7 A Absolutely.

8 Q I wanted to ask you a question about the discussion  
9 that you had about grandiose delusions. Do I take it, then,  
10 that you disagree with Dr. Morris' testimony that it is not so  
11 much the delusion that is the problem for Ms. Barzee, it is her  
12 preoccupation with the delusion?

13 A Would you remind me what Dr. Morris said about that.

14 Q I believe that Dr. Morris and I agreed it is not the  
15 delusion that is the competency concern with Ms. Barzee, it was  
16 her preoccupation with the delusion.

17 A Yeah, I think I would disagree with that. I think it  
18 is both, but, fundamentally, it is the delusional belief  
19 itself. If there is strong conviction in that belief, there is  
20 no flexibility, like she can consider maybe this isn't true,  
21 that that core, fixed belief is impairing competency.  
22 Preoccupation with it, as well. And the way that when you were  
23 cross examining Dr. Morris I understood your point is also  
24 impairing competency. Those are two separate issues.

25 Q Would it be your assessment that anyone who has a

# ADDENDUM B

*United States v. Weston*

 [West Reporter Image \(PDF\)](#)

255 F.3d 873, 347 U.S.App.D.C. 145

[Briefs and Other Related Documents](#)

United States Court of Appeals,  
District of Columbia Circuit.  
UNITED STATES of America, Appellee,  
v.  
Russell Eugene WESTON, Jr., Appellant.  
No. 01-3027.  
Argued May 16, 2001.  
Decided July 27, 2001.

Government sought order permitting forcible administration of antipsychotic drugs to pretrial detainee accused of killing guards at United States Capitol, in order to render detainee competent to stand trial. The United States District Court for the District of Columbia, [Emmet G. Sullivan, J.](#), 69 F.Supp.2d 99, issued order. The Court of Appeals, 206 F.3d 9, remanded. On remand, the District Court, 134 F.Supp.2d 115, reaffirmed its finding that involuntary treatment was medically appropriate and necessary, and detainee appealed. The Court of Appeals, [Randolph](#), Circuit Judge, held that: (1) antipsychotic drugs were medically appropriate; (2) government's interest in bringing detainee to trial was "essential state policy"; and (3) forced medication was necessary in order to restore detainee's competence, and therefore justified.

Affirmed.

[Randolph](#), Circuit Judge, filed concurring opinion joined by Circuit Judge [Sentelle](#).

[Rogers](#), Circuit Judge, filed concurring opinion.


## West Headnotes


[1]  [KeyCite Notes](#)

 [92 Constitutional Law](#)


 [92XII Due Process of Law](#)

 [92k256 Criminal Prosecutions](#)

 [92k268.2 Disadvantaged Persons, Counsel and Trial](#)


 [92k268.2\(2\) k. Incompetents or Psychopaths; Determination of Sanity. Most Cited Cases](#)

 [92 Constitutional Law KeyCite Notes](#)


 [92XII Due Process of Law](#)


 [92k256 Criminal Prosecutions](#)


 [92k272 Execution of Sentence](#)

 [92k272\(2\) k. Imprisonment and Incidents Thereof. Most Cited Cases](#)


 [257A Mental Health KeyCite Notes](#)

 [257AII Care and Support of Mentally Disordered Persons](#)

 [257AII\(A\) Custody and Cure](#)

 [257Ak51 Restraint or Treatment](#)

 [257Ak51.15 k. Involuntary Treatment or Medication. Most Cited Cases](#)

 [257A Mental Health KeyCite Notes](#)



☞ 257AIV Disabilities and Privileges of Mentally Disordered Persons

☞ 257AIV(E) Crimes

☞ 257Ak436 Custody and Confinement

☞ 257Ak436.1 k. In General. Most Cited Cases

Due process liberty interest in avoiding unwanted antipsychotic medication is significant, but not absolute; forcible administration of such medication to prisoner or criminal defendant may be permissible despite his liberty interest if such medication is medically appropriate and necessary. U.S.C.A. Const.Amend. 5.



[2] KeyCite Notes

☞ 257A Mental Health

☞ 257AIV Disabilities and Privileges of Mentally Disordered Persons

☞ 257AIV(E) Crimes

☞ 257Ak436 Custody and Confinement

☞ 257Ak436.1 k. In General. Most Cited Cases

Antipsychotic medication was medically appropriate treatment for paranoid schizophrenic pretrial detainee, potentially warranting forcible administration of medication in order to render detainee competent to stand trial, regardless of detainee's contention that some doctors may have ethical objections to involuntary administration of drugs; consensus in medical profession was that antipsychotic medication was medically appropriate response to detainee's condition. 18 U.S.C.A. § 4241(a).



[3] KeyCite Notes

☞ 92 Constitutional Law

☞ 92XII Due Process of Law

☞ 92k255 Deprivation of Life or Liberty in General

☞ 92k255(5) k. Diseased and Mentally Disordered Persons; Addicts. Most Cited Cases



☞ 92 Constitutional Law KeyCite Notes

☞ 92XII Due Process of Law

☞ 92k256 Criminal Prosecutions

☞ 92k268.2 Disadvantaged Persons, Counsel and Trial

☞ 92k268.2(2) k. Incompetents or Psychopaths; Determination of Sanity. Most Cited Cases



☞ 257A Mental Health KeyCite Notes

☞ 257AIV Disabilities and Privileges of Mentally Disordered Persons

☞ 257AIV(E) Crimes

☞ 257Ak436 Custody and Confinement

☞ 257Ak436.1 k. In General. Most Cited Cases

Forced administration of antipsychotic drugs against wishes of detainee or defendant, i.e. overriding of detainee's or defendant's due process right to refuse medication, requires finding that administration of such medication is necessary to accomplish an essential state policy. U.S.C.A. Const.Amend. 5.



## [4] KeyCite Notes

## 257A Mental Health

## 257AIV Disabilities and Privileges of Mentally Disordered Persons

## 257AIV(E) Crimes

## 257Ak436 Custody and Confinement

257Ak436.1 k. In General. Most Cited Cases

Government's interest in bringing to trial paranoid schizophrenic detainee accused of killing federal guards at United States Capitol was "essential state policy" which could potentially support forced administration of antipsychotic drugs; government's general interest in punishing crime was at its height in such circumstances, and was undiminished by option of civil commitment, which did not address retributive, deterrent, or investigative functions of criminal trial. 18 U.S.C.A. § 4241(a).



## [5] KeyCite Notes

## 92 Constitutional Law

## 92XII Due Process of Law

## 92k256 Criminal Prosecutions

## 92k268.2 Disadvantaged Persons, Counsel and Trial

92k268.2(2) k. Incompetents or Psychopaths; Determination of Sanity. Most Cited Cases257A Mental Health KeyCite Notes

## 257AIV Disabilities and Privileges of Mentally Disordered Persons

## 257AIV(E) Crimes

## 257Ak436 Custody and Confinement

257Ak436.1 k. In General. Most Cited Cases

Forced administration of antipsychotic drugs to paranoid schizophrenic detainee accused of killing federal guards at United States Capitol was justified as necessary to make detainee competent to stand trial, overriding detainee's due process right to refuse medication; trial would serve essential state policy of prosecuting serious crime, there was likelihood that detainee would be rendered competent by drugs, and there was no basis for believing that detainee's ability to testify or to present insanity defense would be impaired. U.S.C.A. Const.Amend. 5; 18 U.S.C.A. § 4241(a).

**\*874 \*\*146** Appeal from the United States District Court for the District of Columbia (98cr00357-01).

Gregory L. Poe, Assistant Federal Public Defender, argued the cause for appellant. With him on the briefs was A. J. Kramer, Federal Public Defender.

David B. Goodhand, Assistant U.S. Attorney, argued the cause for appellee. With him on the brief were Wilma A. Lewis, U.S. Attorney at the time the brief was filed, John R. Fisher and Ronald L. Walutes, Jr., Assistant U.S. Attorneys.

Before: SENTELLE, RANDOLPH, and ROGERS, Circuit Judges.

Opinion for the Court filed by Circuit Judge RANDOLPH.

Concurring opinion filed by Circuit Judge RANDOLPH, with whom Circuit Judge SENTELLE joins.

Concurring opinion filed by Circuit Judge ROGERS.

RANDOLPH, Circuit Judge:

Under the Fifth Amendment's Due Process Clause there is a "significant liberty interest in avoiding the unwanted administration of antipsychotic drugs." *Washington v. Harper*, 494 U.S. 210, 221, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990). This appeal requires us to decide whether the government may administer such drugs to a pretrial detainee against his will in order to render him competent to stand trial.

## I.

On July 24, 1998, an assailant armed with a .38 caliber revolver forced his way past security checkpoints at the United States Capitol. He shot and killed Jacob Chestnut and John Gibson, both officers of the United States Capitol Police. He shot and seriously wounded Douglas McMillan, also an officer of the United States Capitol Police. Russell Eugene Weston, himself seriously wounded by gunfire, was arrested at the scene. The federal government indicted Weston on two counts of murdering a federal law enforcement officer, one count of attempting to murder a federal law enforcement officer, and three counts of using a firearm in a crime of violence.

The government wants to try Weston for these crimes but is presently unable to do so because the district court found him incompetent to stand trial. See *United States v. Weston*, 134 F.Supp.2d 115, 117 (D.D.C.2001); 1 Joint Appendix 45-46 (competency order). The district court accepted the conclusion of a court-appointed forensic psychiatrist that Weston suffers from paranoid schizophrenia, and that the severity of his symptoms renders him incapable of understanding the proceedings against him and assisting in his defense, as required to bring a defendant to trial. See 18 U.S.C. § 4241(a) (statutory competence requirement); see also *Godinez v. Moran*, 509 U.S. 389, 396, 113 S.Ct. 2680, 125 L.Ed.2d 321 (1993) (constitutional competence requirement). The court committed Weston to the custody of the Attorney General "for treatment in a suitable facility\*875 \*\*147 for a reasonable period of time." 1 Joint Appendix 46; see also 18 U.S.C. § 4241(d).

Weston is currently incarcerated "for treatment" at the Federal Correctional Institute in Butner, North Carolina. He is not being treated. Rather, he was placed in solitary confinement under constant observation when he arrived at FCI Butner and remains there today. The Bureau of Prisons apparently placed him in seclusion to "mitigate [his] dangerousness." *Weston*, 134 F.Supp.2d at 130. As an Assistant Director of the Bureau explained, Weston's "mental health seclusion status" is "for very vulnerable inmates, and [is] typically ... reserved for those who present a substantial danger to themselves or somebody else...." 7/24/00 a.m. Tr. at 59. The district court characterized Weston's confinement situation as "simply the warehousing of Weston in a psychotic state. It is not treatment; at best it contains dangerousness." 134 F.Supp.2d at 130-31; see also 4 Joint Appendix 103 (Report of court-appointed expert that "the field places severe limitations on the use of seclusion in clinical psychiatry because [it] is considered to be inherently aversive when used for prolonged periods of time.").

There is treatment available for Weston's illness and its symptoms in the form of antipsychotic medication. The parties agree that such medication is likely the only treatment that can mitigate his schizophrenia and attendant delusions, and thus restore his competence to stand trial. See Brief for Appellant at 5; Brief for Appellee at 12-13. Weston is not currently receiving any such medication because, at a time when he was considered medically competent to make a determination, he refused them. The district court prohibited the Bureau of Prisons from forcibly medicating Weston without a court order.

After two administrative hearings and two district court hearings, the government obtained an order authorizing it to administer antipsychotic medication against Weston's will. See *United States v. Weston*, 69 F.Supp.2d 99 (D.D.C.1999). The district court held that forcible medication was "medically appropriate" and "essential for [Weston's] own safety or the safety of others." *Id.* at 118. It also found that "the government has a fundamental interest in bringing the defendant to trial," but determined that the dangerousness holding made it unnecessary to decide whether that interest

outweighed Weston's right to refuse antipsychotic medication. See *id.* at 118-19. The court declined to consider Weston's claim that forced medication would interfere with his right to a fair trial, holding it was not ripe. See *id.* at 107.

A panel of this court reversed and remanded the case to the district court, holding that the district court's dangerousness finding was not supported by the record. See *United States v. Weston*, 206 F.3d 9 (D.C.Cir.2000) (per curiam). The panel also reversed the district court's determination that Weston's Sixth Amendment right to a fair trial claim was not ripe, holding that "because antipsychotic medication may affect the defendant's ability to assist in his defense, postmedication review may come too late to prevent impairment of his Sixth Amendment right." *Id.* at 14 (citations omitted). The panel also directed the district court to consider Weston's argument that medical ethics preclude forcibly medicating a defendant to make him competent for trial in a case that might carry the death penalty. See *id.* at 14 n. 3.

On remand, the district court again held that the Bureau of Prisons could forcibly medicate Weston. It concluded that antipsychotic medication was medically appropriate\*876 \*\*148 and "essential to control and treat Weston's dangerousness to others." *Weston*, 134 F.Supp.2d at 127, 131. The district court also held that the "government has an essential interest in bringing Weston to trial" given "the serious and violent nature of the charges, that the immediate victims were federal law enforcement officers performing their official duties, and that the killings took place inside the U.S. Capitol amid a crowd of innocent bystanders." *Id.* at 132. The court concluded that forcible medication would not interfere with Weston's right to a fair trial, and could in some respects enhance his ability to exercise that right by improving his mental function. See *id.* at 132-38.

In this appeal, Weston claims that administering antipsychotic drugs against his will violates his Fifth Amendment due process liberty interest "in avoiding unwanted bodily intrusion" and implicates his right to a fair trial. See Brief for Appellant at 37-38. In earlier stages of this case, Weston asserted a First Amendment right to freedom from compulsory medication and challenged the Bureau of Prisons' administrative procedures under the Fifth Amendment's Due Process Clause.<sup>FN1</sup> He has not raised either issue here so we do not consider them. We affirm the district court's conclusion that the government's interest in administering antipsychotic drugs to make Weston competent for trial overrides his liberty interest, and that restoring his competence in such manner does not necessarily violate his right to a fair trial.

FN1. Weston refers in footnote 9 of his brief to the First Amendment, the Fourth Amendment, and "privacy interests" not attributed to any particular part of the Constitution. He has supplied no supporting arguments and we therefore will disregard his references. See, e.g., *Washington Legal Clinic for the Homeless v. Barry*, 107 F.3d 32, 39 (D.C.Cir.1997).

## II.



[1] [2] The due process liberty interest in avoiding unwanted antipsychotic medication may be "significant," but it is not absolute. See *Kansas v. Hendricks*, 521 U.S. 346, 356, 117 S.Ct. 2072, 138 L.Ed.2d 501 (1997); *United States v. Salerno*, 481 U.S. 739, 750-51, 107 S.Ct. 2095, 95 L.Ed.2d 697 (1987); *Youngberg v. Romeo*, 457 U.S. 307, 320, 102 S.Ct. 2452, 73 L.Ed.2d 28 (1982). In *Washington v. Harper* and later in *Riggins v. Nevada*, the Supreme Court recognized that the government may, under certain circumstances, forcibly administer antipsychotic medication to a prisoner or criminal defendant despite his liberty interest, provided such medication is "medically appropriate." See *Riggins v. Nevada*, 504 U.S. 127, 135, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992); *Washington v. Harper*, 494 U.S. 210, 220, 222-23 & n. 8, 226-27, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990). With respect to Weston, there is no doubt that this latter condition has been met.

Whether a proposed course of action is "medically appropriate" obviously depends on the judgment of medical professionals. See *Harper*, 494 U.S. at 231, 233-34, 110 S.Ct. 1028; *Youngberg*, 457 U.S. at

322-23, 102 S.Ct. 2452; *Vitek v. Jones*, 445 U.S. 480, 495, 100 S.Ct. 1254, 63 L.Ed.2d 552 (1980); *Parham v. J.R.*, 442 U.S. 584, 606-07, 609, 99 S.Ct. 2493, 61 L.Ed.2d 101 (1979); *Addington v. Texas*, 441 U.S. 418, 429, 99 S.Ct. 1804, 60 L.Ed.2d 323 (1979). The district court relied on several experts in concluding that "[a]ntipsychotic medication is the medically acceptable and indicated treatment for Weston's illness." *Weston*, 134 F.Supp.2d at 122.

The district court measured the medical appropriateness of antipsychotic medication by examining the capacity of antipsychotic drugs to alleviate Weston's schizophrenia (the medical benefits) against their capacity to produce harm **\*\*149 \*877** (the medical costs, or side effects). See *id.* at 123. Numerous experts testified that antipsychotic medication is the medically appropriate treatment for Weston's illness.<sup>FN2</sup> While there are potential side effects,<sup>FN3</sup> the professional judgment of the medical experts was that "each of these potential side effects is generally manageable." *Id.* at 123, 125. The short of the matter is that the record leaves no basis for doubting the district court's conclusion that antipsychotic medication is the medically appropriate treatment for Weston's condition.

<sup>FN2</sup>. See, e.g., 8/20/99 a.m. Tr. at 59 (Dr. Johnson testifying that the standard of care for treating schizophrenia is antipsychotic medication); 4 Joint Appendix 103 (Report of Dr. Daniel stating that "[a]ntipsychotic medication is essential to the treatment of psychotic disorders such as schizophrenia. Psychotherapy without antipsychotic medication is not considered to be an effective treatment for schizophrenia."); 7/25/00 p.m. Tr. at 11 (Dr. Deprato's testimony that "[t]he diagnosis of paranoid schizophrenia is appropriately treated with antipsychotic medication"); 7/26/00 a.m. Tr. at 64 (Dr. Zonana's testimony: Question: "To your knowledge is there any hospital in this country that would not attempt to treat this patient with antipsychotic medication to address the illness as you understand it based on the materials that you've had an opportunity to sit in and review?" Answer: "Well, I think that is the standard treatment of choice these days [and] if you don't offer and try to use medication in a situation like this, it is negligent.").

<sup>FN3</sup>. There are two types of antipsychotic medication-the "typicals" and the "atypicals." The government proposed to use typicals, which are an older generation of antipsychotics. The district court found:

Typical antipsychotics can produce the following side effects: (1) dystonic or acute dystonic reactions, which involve a stiffening of muscles; (2) acuesthesia, which is restlessness or an inability to sit still; (3) Parkinsonian side effects, which can slow an individual; (4) tardive dyskinesia, which causes repetitive, involuntary tic-like movements of the face, eyelids, and mouth; (5) neuroleptic malignant syndrome ("NMS"), which causes temperature control problems and stiffness; and (6) perioral tremor, referred to as rabbit syndrome because of the mouth movements associated with it.

134 F.Supp.2d at 123. The atypicals, which the government has not ruled out, are newer and "have a more favorable side effect profile." See *id.* at 124. The court found that side effects from atypicals include: (1) Agranulocytosis, which could result in death but for which "there is a highly effective monitoring system to prevent this result"; (2) sedation; (3) weight gain; (4) seizures; and (5) problems with lipid metabolism. See *id.* It appears that antipsychotic medications could also alter Weston's demeanor, emotional affect, and cognitive function. See 7/24/00 p.m. Tr. at 49-50; 7/25/00 a.m. Tr. at 22-24; 7/26/00 a.m. Tr. at 62-63.

Weston claims that the ethical obligations a doctor owes a patient preclude forcible medication in these circumstances. As he sees it, "the question whether the administration of antipsychotic medication is medically appropriate is different from the question whether treatment is therapeutically appropriate." Brief for Appellant at 18. Thus, "[t]he context in which the forced medication issue arises and the state purpose are relevant considerations for the physician to decide whether it is ethical to force-medicate." *Id.* If the state's purpose is to make one competent for trial, Weston argues, then a doctor must consider alternatives such as civil commitment. See *id.* These ethical norms purportedly derive from the Hippocratic Oath and the 1982 United Nations Principles of Medical

Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment. See Brief for Appellant at 19.

No source of legal authority—neither Bureau of Prisons regulations, nor the statute governing treatment of incompetent pretrial detainees, nor the Constitution **\*878**—makes **\*\*150** medical ethics relevant to the determination whether the government can forcibly medicate Weston. Even if a particular doctor had ethical objections to administering antipsychotic drugs to a non-consenting patient, this would not undercut the consensus in the medical profession that antipsychotic medication is the medically appropriate response to Weston's condition. <sup>FN4</sup>

FN4. Defense counsel also claims that Weston's decision while he was medically competent not to take antipsychotic medication makes such medication medically inappropriate. See Brief for Appellant at 45. We shall assume arguendo that Weston's previous decision reflects his current informed judgment (which of course is unknowable). Nonetheless, withholding of consent does not make a treatment medically inappropriate. In *Harper*, for instance, the inmate reportedly said he "would rather die than take medication," 494 U.S. at 239, 110 S.Ct. 1028 (Stevens, J., separate opinion), but the Court approved the treatment as in the inmate's medical interest.

### A. Mitigating Dangerousness

A pretrial detainee's liberty interest in avoiding unwanted antipsychotic medication gives way when the medication is essential to mitigate the detainee's dangerousness: "Nevada certainly would have satisfied due process if the prosecution had demonstrated, and the District Court had found, that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of [the pretrial detainee's] own safety or the safety of others." *Riggins*, 504 U.S. at 135, 112 S.Ct. 1810. The district court applied this standard to Weston's situation and twice found antipsychotic medication medically appropriate and essential for his safety or the safety of those around him. See *Weston*, 134 F.Supp.2d at 121-32; *Weston*, 69 F.Supp.2d at 107-10.

On appeal of the district court's first decision, a panel of this court found the record insufficient to support application of the *Riggins* standard. Much of the evidence focused on the government's competency-for-trial justification—which the district court did not adopt—and the limited evidence supporting the dangerousness justification "indicates that in his current circumstances Weston poses no significant danger to himself or to others." *Weston*, 206 F.3d at 13. The panel relied on the testimony of a Public Health Service physician assigned to FCI Butner that "[g]iven [Weston's] immediate containment situation, I feel confident that we can prevent him from harming himself or others under his immediate parameters of incarceration where he is in an individual room with limited access to anything that he could harm himself with or harm anyone else with, and he remains under constant observation." 2 Joint Appendix 121; *Weston*, 206 F.3d at 13. The panel concluded that involuntary medication was not "essential" for safety and instructed the district court that "[i]f the government advances the medical/safety justification on remand, it will need to present additional evidence showing that either Weston's condition or his confinement situation has changed since the hearing so as to render him dangerous." *Id.*

On remand, the district court received additional evidence showing that Weston's condition had deteriorated. In view of this evidence, the court once again found that Weston posed such a danger that medicating him was warranted. We think the previous panel's decision likely precluded that finding. That panel held that Weston's situation in confinement—total seclusion and constant observation—obviated any significant danger he might pose to himself or others. There appears no basis to believe that Weston's worsening condition renders him more dangerous **\*879** **\*\*151** given his near-total incapacitation. Weston remains in seclusion under constant observation. Absent a showing that Weston's condition now exceeds the institution's ability to contain it through his present state of confinement, the prior decision appears to preclude a finding of dangerousness. See *LaShawn*

*A. v. Barry*, 87 F.3d 1389, 1393, 1395 (D.C.Cir.1996) (en banc) (law-of-the-case and law-of-the-circuit doctrines). We need not determine whether our concurring colleague's different interpretation of the previous panel's decision is correct in view of our affirmance of the district court's competency-for-trial ground of decision. See Concurring Op. of Rogers, J., at 889-90.

### **B. Restoring Competence to Stand Trial**

In *Riggins*, the Court prescribed the conditions sufficient for a dangerousness justification, but explicitly declined to "prescribe ... substantive standards" for determining when other government interests override a pretrial detainee's liberty interest in refusing antipsychotic medication. See *Riggins*, 504 U.S. at 136, 112 S.Ct. 1810; see also *Weston*, 206 F.3d at 12-13 (also declining to prescribe substantive standards). The Court did, however, suggest that the governmental interest in restoring a pretrial detainee's competence to stand trial could override his liberty interest: "the State might have been able to justify medically appropriate, involuntary treatment with [antipsychotic medication] by establishing that it could not obtain an adjudication of [the pretrial detainee's] guilt or innocence by using less intrusive means." *Riggins*, 504 U.S. at 135, 112 S.Ct. 1810.

"The substantive issue involves a definition of the protected constitutional interest, as well as identification of the conditions under which competing state interests might outweigh it." *Harper*, 494 U.S. at 220, 110 S.Ct. 1028 (quoting *Mills v. Rogers*, 457 U.S. 291, 299, 102 S.Ct. 2442, 73 L.Ed.2d 16 (1982)) (internal brackets omitted); see also *Foucha v. Louisiana*, 504 U.S. 71, 116, 112 S.Ct. 1780, 118 L.Ed.2d 437 (1992) (Thomas, J., dissenting) ("The standard of review determines when the Due Process Clause ... will override a State's substantive policy choices, as reflected in its laws."). *Weston* argues that the appropriate substantive standard is strict scrutiny and that involuntary medication must be "narrowly tailored to achieve a compelling government interest." See Brief for Appellant at 36-37; accord *United States v. Brandon*, 158 F.3d 947, 957 (6th Cir.1998) (strict scrutiny applies to determination whether governmental interest in medicating nondangerous pretrial detainee to make him competent for trial outweighs liberty interest); *Bee v. Greaves*, 744 F.2d 1387, 1396 (10th Cir.1984) (requiring use of "less restrictive alternatives"); see also *Kulas v. Valdez*, 159 F.3d 453, 455 (9th Cir.1998) (using heightened scrutiny under *Riggins*); *United States v. Sanchez-Hurtado*, 90 F.Supp.2d 1049, 1055 (S.D.Cal.1999) (same); *Khiem v. United States*, 612 A.2d 160, 165-66 (D.C.1992) (as amended on rehearing) (applying *Riggins* and requiring "a showing of overriding justification and medical appropriateness"). The government argues for an arbitrary and capricious standard like that employed to review administrative agency action. See Brief for Appellee at 22-27; accord *Harper*, 494 U.S. at 223, 110 S.Ct. 1028 (applying reasonableness standard to forcible medication of prisoners to mitigate dangerousness); *Weston*, 206 F.3d at 14-15 (Henderson, J., concurring); *United States v. Charters*, 863 F.2d 302, 306 (4th Cir.1988) (en banc) (liberty interest "is protected against arbitrary and capricious actions by government officials"); *United States v. Morgan*, 193 F.3d 252, 262 (4th Cir.1999) ("under *Charters*, the determination\*880 \*\*152 of whether to forcibly medicate a pretrial detainee ... rests upon the professional judgment of institutional medical personnel, subject only to judicial review for arbitrariness"); *United States v. Keeven*, 115 F.Supp.2d 1132, 1137 (E.D.Mo.2000) (following *Morgan*); cf. *Jurasek v. Utah State Hosp.*, 158 F.3d 506, 511 (10th Cir.1998) (applying *Harper*'s reasonableness standard to civilly committed patient); see also *Charters*, 863 F.2d at 312-13 (professional judgment standard from *Youngberg v. Romeo*); *Morgan v. Rabun*, 128 F.3d 694, 697 (8th Cir.1997) (same).

The Supreme Court denied that it had adopted a strict scrutiny standard in *Riggins*. See *Riggins*, 504 U.S. at 136, 112 S.Ct. 1810. It also appeared not to apply a reasonableness test or its various analogues: arbitrary and capricious, rational basis, or exercise of professional judgment. Rather, the opinion's language suggests some form of heightened scrutiny: the emphasis on the severity of infringement antipsychotic drugs impose on an individual's liberty interest, see *id.* at 134, 112 S.Ct. 1810; the reasoning that "forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of *overriding* justification," *id.* at 135, 112 S.Ct. 1810 (emphasis added); the statement that medicating to mitigate dangerousness must be "essential" and that the trial court must consider "less intrusive alternatives," *id.*; and the criticism of the district court's failure to find that "safety considerations or other compelling concerns outweighed *Riggins*' [liberty] interest," *id.* at 136, 112 S.Ct. 1810.



[3] We think the appropriate standard is the one the Court set forth in the penultimate paragraph where it noted the lack of a “finding that might support a conclusion that administration of antipsychotic medication was necessary to accomplish an essential state policy....” *Id.* at 138, 112 S.Ct. 1810. Although that paragraph addressed trial prejudice, it outlines the standard the state failed to meet in ascertaining whether a governmental interest outweighs a right to avoid antipsychotic medication. Accordingly, to medicate Weston, the government must prove that restoring his competence to stand trial is necessary to accomplish an essential state policy.<sup>FN5</sup>

FN5. The district court held the government to a clear-and-convincing-evidence burden of proof. See 134 F.Supp.2d at 121 & n. 12. Neither party challenges this determination.

### 1. The Essential State Policy in Adjudicating Criminality

Preventing and punishing criminality are essential governmental policies. The Supreme Court has recognized that preventing crime is a compelling governmental interest. See *Schall v. Martin*, 467 U.S. 253, 264, 104 S.Ct. 2403, 81 L.Ed.2d 207 (1984); *United States v. Salerno*, 481 U.S. 739, 749-50, 107 S.Ct. 2095, 95 L.Ed.2d 697 (1987). This interest lies not just in incapacitating dangerous criminals, but also in demonstrating that transgressions of society's prohibitions will be met with an appropriate response by punishing offenders. See *Kansas v. Hendricks*, 521 U.S. 346, 361-62, 117 S.Ct. 2072, 138 L.Ed.2d 501 (1997); *Foucha v. Louisiana*, 504 U.S. 71, 80, 112 S.Ct. 1780, 118 L.Ed.2d 437 (1992). The Court has repeatedly adverted to the government's “compelling interest in finding, convicting, and punishing those who violate the law.” *Moran v. Burbine*, 475 U.S. 412, 426, 106 S.Ct. 1135, 89 L.Ed.2d 410 (1986); accord *Texas v. Cobb*, 532 U.S. 162, ---, 121 S.Ct. 1335, 1343, 149 L.Ed.2d 321 (2001); *Gray v. Maryland*, 523 U.S. 185, 202, 118 S.Ct. 1151, 140 L.Ed.2d 294 (1998) (Scalia, J., dissenting); *McNeil v. Wisconsin*, 501 U.S. 171, 181, 111 S.Ct. 2204, 115 L.Ed.2d 158 (1991); \*881 \*\*153 *Richardson v. Marsh*, 481 U.S. 200, 210, 107 S.Ct. 1702, 95 L.Ed.2d 176 (1987); *Garrett v. United States*, 471 U.S. 773, 796, 105 S.Ct. 2407, 85 L.Ed.2d 764 (1985) (O'Connor, J., concurring).

The Court in *Riggins* recognized the strength of the government's policy in adjudicating criminality when it stated that the government “might” be able to involuntarily medicate a defendant if “it could not obtain an adjudication of [his] guilt or innocence by using less intrusive means,” 504 U.S. at 135, 112 S.Ct. 1810, and when it cited Justice Brennan's statement that “Constitutional power to bring an accused to trial is fundamental to a scheme of ‘ordered liberty’ and prerequisite to social justice and peace,” *id.* at 135-36, 112 S.Ct. 1810 (quoting *Illinois v. Allen*, 397 U.S. 337, 347, 90 S.Ct. 1057, 25 L.Ed.2d 353 (1970) (Brennan, J., concurring)). We do not believe the Court's use of “might” reflects any tentativeness about whether the government could ever justify medicating to restore competence to stand trial. If that were what the Court had in mind we doubt that it would have included the statement. We read “might,” rather, as indicating that the interest in adjudicating criminality is not necessarily an essential state policy under all circumstances. Cf. *Brandon*, 158 F.3d at 960-61 (no compelling interest in trying man accused of sending a threatening letter; factors relevant to this determination include seriousness of the offense, whether the pretrial detainee is dangerous, and whether the detainee will be released if not tried); *Khiem*, 612 A.2d at 176 & n. 1 (Ferren, J., dissenting from denial of rehearing en banc) (“Whereas the District may have a compelling state interest in force-medicating Khiem [to try him for murder], the District will not necessarily have such an interest in force-medicating pretrial detainees charged with lesser crimes.”).



[4] We need not decide under what circumstances trying and punishing offenders is not “essential.” The government's interest in finding, convicting, and punishing criminals reaches its zenith when the crime is the murder of federal police officers in a place crowded with bystanders where a branch of government conducts its business. The Court made the point in *Salerno*: “While the Government's general interest in preventing crime is compelling, even this interest is heightened



when the Government musters convincing proof that the arrestee, already indicted or held to answer for a serious crime, presents a demonstrable danger to the community. Under these narrow circumstances, society's interest in crime prevention is at its greatest." 481 U.S. at 750, 107 S.Ct. 2095; see also *Khiem*, 612 A.2d at 167; but see *Bee v. Greaves*, 744 F.2d 1387, 1395 (10th Cir.1984). The statutory sentences for the crimes Weston is accused of committing—life in prison and death—reflect the intensity of the government's interest in bringing those suspected of such crimes to trial. See 18 U.S.C. §§ 1111, 1114.

Weston concedes that in "the ordinary case, the strength of the government's interest in trying a defendant accused of first degree murder is undisputed," but argues that when "the government seeks to forcibly medicate a defendant in order to try him, however, the case is no longer ordinary, because presumptions against forced medication have deep roots in the law." Brief for Appellant at 43. This argument is a reprise of the medical ethics point we considered and rejected in determining whether antipsychotic medication is medically appropriate. It has no more purchase here. The "presumption" against forced medication goes to the importance of Weston's constitutional right to refuse antipsychotic drugs (which we agree is substantial), not to the nature of the government's countervailing interest.

We also do not believe that the "governmental interest in medicating a defendant \*882 \*\*154 in order to try him is diminished ... by the option of civil commitment." Note, *Riggins v. Nevada: Toward a Standard for Medicating the Incompetent Defendant to Competence*, 71 N.C. L.REV. 1206, 1223 (1993). The civil commitment argument assumes that the government's essential penological interests lie only in incapacitating dangerous offenders. It ignores the retributive, deterrent, communicative, and investigative functions of the criminal justice system, which serve to ensure that offenders receive their just deserts, to make clear that offenses entail consequences, and to discover what happened through the public mechanism of trial. Civil commitment addresses none of these interests. In Weston's case, civil commitment would be based on his present mental condition, not on his culpability for the crimes charged: "criminal responsibility at the time of the alleged offenses ... is a distinct issue from his competency to stand trial." *Jackson v. Indiana*, 406 U.S. 715, 739, 92 S.Ct. 1845, 32 L.Ed.2d 435 (1972); see also 18 U.S.C. § 4241(f) ("A finding by the court that the defendant is mentally competent to stand trial shall not prejudice the defendant in raising the issue of his insanity as a defense to the offense charged, and shall not be admissible as evidence in a trial for the offense charged.").

## 2. Involuntary Medication is Necessary and there are no Less Intrusive Means

The sole constitutional mechanism for the government to accomplish its essential policy is to take Weston to trial. See U.S. CONST. amend. V (no deprivation of life, liberty, or property without due process). Antipsychotic medication is necessary because, as the district court found, "antipsychotic medication is the only therapeutic intervention available that could possibly improve Weston's symptom picture, lessen his delusions, and make him competent to stand trial." *Weston*, 134 F.Supp.2d at 132. The government cannot "obtain an adjudication of [Weston's] guilt or innocence by using less intrusive means." *Riggins*, 504 U.S. at 135, 112 S.Ct. 1810.



[5] Although Weston does not propose any alternative means, he claims that the fit between involuntary medication and the government's interest is not sufficiently tight in two respects. First, he argues that the medication will not restore his competence to stand trial because he is not likely to respond to it. Second, he contends that the medication's mind-altering properties and likely side effects will prejudice his right to a fair trial such that the government could not lawfully try him even if his competence were restored. Either way, the argument goes, there is an insufficient probability that forcible medication will satisfy the government's interest.

We will treat what Weston styles the "narrow tailoring" requirement of strict scrutiny as an attack on the "necessity" of antipsychotic medication. In determining whether a governmental interest overrides a constitutional right, courts examine not only the nature of the right and the strength of the

countervailing interest, but also the fit between the interest and the means chosen to accomplish it. This inquiry entails a predictive judgment about the probable efficacy of the means to satisfy the interest. In the terms of this case, antipsychotic medication may not be "necessary" if its use will not permit the government to try Weston.

That antipsychotic medication must be necessary to restore Weston's competence to stand trial does not mean there must be a 100% probability that it will produce this result. As the Court has recognized, "necessity" may mean "absolute physical necessity or inevitability" or "that which is only convenient, useful, appropriate, suitable, proper, or conducive to the end \*883 \*\*155 sought." Webster v. Reproductive Health Servs., 492 U.S. 490, 515 n. 13, 109 S.Ct. 3040, 106 L.Ed.2d 410 (1989) (plurality opinion) (quoting Black's Law Dictionary); see also Board of Trustees v. Fox, 492 U.S. 469, 476-77, 109 S.Ct. 3028, 106 L.Ed.2d 388 (1989). Even narrow tailoring in strict scrutiny analysis does not contemplate a perfect correspondence between the means chosen to accomplish a compelling governmental interest. See Burson v. Freeman, 504 U.S. 191, 206-10, 112 S.Ct. 1846, 119 L.Ed.2d 5 (1992) (plurality opinion).

The government has established a sufficient likelihood that antipsychotic medication will restore Weston's competence while preserving his right to a fair trial. See Brandon, 158 F.3d at 960. The district court acknowledged that "it is not certain that the medication will restore Weston's competency," but "credit[ed] the ... testimony of the mental health experts that this outcome is likely." Weston, 134 F.Supp.2d at 132. The government presented evidence that antipsychotic medication mitigated symptoms for at least 70 percent of patients. See 7/24/00 p.m. Tr. at 108-09; 8/20/99 a.m. Tr. at 56; 11/15/00 a.m. Tr. at 57. Dr. Johnson testified that the response rate is probably higher with the atypicals. See 7/24/00 p.m. Tr. at 108-09. The government also provided reason to believe that the probability of restoring competence might be higher in Weston's case because of Weston's "relatively little exposure to antipsychotic medication" and his generally positive response to the limited medication he received in 1996. See Weston, 134 F.Supp.2d at 122; see also 8/20/99 a.m. Tr. at 56; 7/27/00 a.m. Tr. at 120-21; 4 Joint Appendix 105 (Report of Dr. Daniel).

The small possibility that antipsychotic medication will not make Weston competent for trial is certainly tolerable considering that antipsychotic medication is the sole means for the government to satisfy its essential policy in adjudicating the murder of federal officers. See Burson, 504 U.S. at 207-08, 112 S.Ct. 1846 (emphasizing that the means chosen is the "only way" to satisfy the state's compelling interest). The district court made the most precise predictive judgment it could in this context. See 8/20/99 a.m. Tr. at 56 (Dr. Johnson's testimony that "you are unable to predict in the individual case whether that individual will actually respond").

Weston points out that there is also a possibility that antipsychotic medication could prejudice his right to a fair trial by, for instance, altering his courtroom demeanor, interfering with his recollection and ability to testify, and obstructing his right to present an insanity defense. We agree with the district court that "[t]here is no reason to conclude, at this time, that involuntary medication would preclude Weston from receiving a fair trial." Weston, 134 F.Supp.2d at 137.

The general right to a fair trial includes several specific rights such as the right to be tried only while competent, that is, while able to understand the proceedings, consult with counsel, and assist in the defense. See Drope v. Missouri, 420 U.S. 162, 171-72, 95 S.Ct. 896, 43 L.Ed.2d 103 (1975). As we determined, there is a sufficiently high probability that antipsychotic medication will restore Weston's competence to stand trial. The district court found and the evidence indicates that "a strong likelihood exists that medication will enhance some of Weston's trial rights, particularly his right to consult with counsel and to assist in his defense." Weston, 134 F.Supp.2d at 133.<sup>FN6</sup>

FN6. See 7/24/00 p.m. Tr. at 8 (Dr. Johnson's testimony that "I would really expect him, from a mental status standpoint, to be functioning in a much enhanced manner over his current psychotic state to the point where I believe his competence could be restored"); *id.* at 9 (Dr. Johnson stating that "I actually firmly believe that treatment with the medication will enhance his ability to follow the issues at the trial"); 7/25/00 a.m. Tr. at 24 (Dr. Johnson's testimony that "successful treatment would result in a decrease in his

delusional thinking, hopefully a resolution of that, an increase in his attention, ability to concentrate, and a change in his affect, or the way his mood appears to someone who is looking onto the situation. His preoccupation with his delusional system has led me to believe at various points that he has also experienced some hallucinatory phenomena, and I would expect that to resolve.”).

**\*884 \*\*156** Another aspect of the right to a fair trial is Weston's right to testify and “to present his own version of events in his own words.” *Rock v. Arkansas*, 483 U.S. 44, 49, 52, 107 S.Ct. 2704, 97 L.Ed.2d 37 (1987). The defense is concerned that the medication might affect Weston's memory and his capacity to relate his delusions and other aspects of his mental state at the time of the crime, which in turn “may impair his ability to mount an effective insanity defense.” *Weston*, 206 F.3d at 21 (Tatel, J., concurring); see also 18 U.S.C. § 17 (affirmative defense of insanity). But the record contains no basis to suppose that antipsychotic drugs will prevent Weston from testifying in a meaningful way. Rather, it indicates that medication will more likely improve Weston's ability to relate his belief system to the jury. See 7/24/00 p.m. Tr. at 49-51. The benefits of antipsychotic medication in terms of Weston's ability to understand the proceedings and communicate with his attorneys presumably will also translate into an improved capacity to communicate from the witness stand. And although memory loss is a potential side effect, Dr. Johnson testified that she thought “he'd be able to remember his belief system.” 7/24/00 p.m. Tr. at 50 (also stating that “I don't think the treatment would impact his memory”); see also 7/25/00 a.m. Tr. at 4-5 (Dr. Johnson's testimony that “I don't expect him to lose the memory of his delusional beliefs as a result of treatment”).

There is a possibility that the medication could affect Weston's behavior and demeanor on the witness stand such that the jury might regard his “synthetically sane” testimony as inconsistent with a claim of insanity. As Justice Kennedy put it in *Riggins*, “[i]f the defendant takes the stand ... his demeanor can have a great bearing on his credibility and persuasiveness, and on the degree to which he evokes sympathy.” *Riggins*, 504 U.S. at 142, 112 S.Ct. 1810 (Kennedy, J., concurring). We recognize this small risk, but we see little basis to suppose that the jury will take Weston's testimony (if he decides to testify) as an indication that he must have been sane at the time of the crime, or that he is making it up, or that he deserves no sympathy. There is ample evidence of Weston's history of mental illness and bizarre behavior; the jury's overall impression of Weston will depend as much on this evidence as his testimony.

The district court also correctly held that a defendant does not have an absolute right to replicate on the witness stand his mental state at the time of the crime. See *Weston*, 134 F.Supp.2d at 134. A defendant asserting a heat-of-passion defense to a charge of first degree murder does not have the right to whip up a frenzy in court to show his capacity for rage, nor does a defendant claiming intoxication have the right to testify under the influence. See *Weston*, 206 F.3d at 15 (Henderson, J., concurring). There is little meaningful distinction between these cases and medication-induced competence to stand trial. Either way, the defendant's mental state on the stand is different from the mental state he claims to have operated under at the time of the crime. The tolerable level **\*885 \*\*157** of difference no doubt increases in a case like this where there is substantial evidence of mental state other than the defendant's present appearance.

Weston will not have to rely solely on his own testimony to show his state of mind on July 24, 1998. Involuntary medication therefore stands little chance of impairing his right to present an insanity defense. There is extensive documentation and testimony concerning Weston's delusional system, his history of mental illness, and his “behavior, appearance, speech, actions, and extraordinary or bizarre acts ... over a significant period.” *Weston*, 134 F.Supp.2d at 135-36. Multiple experts have examined Weston and presumably may testify. Many of these examinations no doubt related to his trial competence, but “[t]he tapes and psychiatric reports ... document Weston's delusional state over several years.” *Id.* at 135. There is also a taped interview in which Weston discussed his delusional beliefs with the Central Intelligence Agency. See *id.* at 135 n. 22. Given the wealth of expert and lay testimony and other documentation the district court described, see *id.* at 135-36, Weston's insanity defense does not stand or fall on his testimony alone.

A third trial right that could be implicated by antipsychotic medication is Weston's right to be present at trial in a state that does not prejudice the factfinder against him. See *Estelle v. Williams*, 425 U.S.

501, 503-04, 96 S.Ct. 1691, 48 L.Ed.2d 126 (1976); *Illinois v. Allen*, 397 U.S. 337, 338, 344, 90 S.Ct. 1057, 25 L.Ed.2d 353 (1970). To the extent the medication alters Weston's demeanor, courtroom behavior, or reactions to events in the courtroom, it may cause the jury to see Weston in a state that might seem inconsistent with a claim of insanity. It could also produce a flattened emotional affect that could convey to the jury a lack of remorse, a critical consideration if this case proceeded to sentencing.

Here again the record indicates that medication will likely enhance rather than impair Weston's right to a fair trial. Dr. Johnson stated that medication "will alter [Weston's demeanor] to the extent that it will be more a return to his baseline non-psychotic state. I would anticipate he would have less blunting or flattening of his affect. He would be able to respond more appropriately from an emotional standpoint with his facial expression than he is now." 7/24/00 p.m. Tr. at 8; *see also* 7/25/00 a.m. Tr. at 22-24 (Dr. Johnson agreeing with the proposition that, with medication, Weston's "expressions potentially could be more appropriate to the context of what's occurring in the courtroom"; also, her testimony that "[i]t is the patient who is over-medicated or whose side effects are not managed who would demonstrate an increased lack of responsiveness").

The possibility of side effects from antipsychotic medication is undeniable, but the ability of Weston's treating physicians and the district court to respond to them substantially reduces the risk they pose to trial fairness. The district court found that Weston's doctors can manage side effects in a number of ways: "the Court credits the testimony of the government experts and Dr. Daniel, the independent expert, that the side effects of medication are manageable through adjustments in the timing and amount of the doses, and through supplementary medications." *Weston*, 134 F.Supp.2d at 137; *see also* 11/15/00 a.m. Tr. at 125 (Dr. Daniel's testimony that antipsychotic medications have side effects but "[g]enerally they can be treated or an adjustment made in the medication, or the medication replaced with a different one. There's generally a way to deal with the side effects."); 4 Joint Appendix 102 (Statement in Dr. Daniel's report \*886 \*\*158 to the district court that "the side effects can most often be managed or an alternative course of treatment provided to the benefit of the patient. General experience with antipsychotics, particularly the newer medications, indicates that given their benefits they are reasonably safe and well-tolerated."). As the Court wrote in *Harper*, the "risks associated with antipsychotic drugs are for the most part medical ones, best assessed by medical professionals." 494 U.S. at 233, 110 S.Ct. 1028.<sup>FN7</sup>

<sup>FN7</sup>. Antipsychotic drugs have progressed since Justice Kennedy discussed their side effects in *Riggins*. There is a new generation of medications having better side effect profiles. *See Weston*, 134 F.Supp.2d at 134 (citing Justice Kennedy's concurrence and writing that "[a]dvances in the primary antipsychotic medications and adjunct therapies make such side effects less likely"); Paul A. Nidich & Jacqueline Collins, *Involuntary Administration of Psychotropic Medication: A Federal Court Update*, 11 No. 4 HEALTH LAWYER 12, 13 (May 1999) ("[I]n light of the progress made in the development of new antipsychotic medications since the Supreme Court's *Riggins* decision in 1992, the courts should revisit this issue with an open mind.... [Because of new atypicals,] the fear of side effects should not weigh heavily in the decision whether to treat pretrial detainees or civilly committed persons with antipsychotic medication against their will when that treatment is medically appropriate."). Although the government presently plans to medicate Weston with the older generation of typicals, it could switch to the newer atypicals if side effects from the typicals threaten to impair his right to a fair trial. The district court analyzed the side effects of both. *See Weston*, 134 F.Supp.2d at 123-25. Dr. Johnson testified that Weston cannot be treated with atypicals unless he agrees to take them orally. *See* 7/24/00 a.m. Tr. at 108-09. The parties dispute whether Weston would so agree. When Weston originally withheld consent to antipsychotic medication, he indicated that he would comply with court-ordered medication. *See* 5/28/99 a.m. Tr. at 3.

The district court also has measures at its disposal: "If Weston is medicated and his competency is restored, the Court is willing to take whatever reasonable measures are necessary to ensure that his rights are protected. This may include informing the jurors that Weston is being administered mind-

altering medication, that his behavior in their presence is conditioned on drugs being administered to him at the request of the government, and allowing experts and others to testify regarding Weston's unmedicated condition, the effects of the medication on Weston, and the necessity of medication to render Weston competent to stand trial." *Weston*, 134 F.Supp.2d at 137. Weston is free to propose other options.

There is a very high probability that involuntary medication will serve the government's essential interest in rendering Weston "competent to stand trial in a proceeding that is fair to both parties." *Brandon*, 158 F.3d at 954.<sup>FN8</sup> Given the lack **\*887 \*\*159** of alternative means for the government to satisfy its essential policy, we cannot demand more.

FN8. Although the bulk of Weston's fair trial argument relates to the narrow tailoring aspect of his Fifth Amendment substantive due process argument, he makes a fleeting reference to an independent right to a fair trial in arguing for strict scrutiny: "Weston's Fifth and Sixth Amendment rights to a fair trial are also at stake because the forced administration of antipsychotic medication may 'have a prejudicial effect on [Weston's] physical appearance at trial' and have an adverse effect on his 'ability to participate in his own defense.'" Brief for Appellant at 37. To the extent this cursory reference suffices to raise this claim, this is not the occasion to evaluate it. Whether antipsychotic medication will impair Weston's right to a fair trial is best determined when the actual effects of the medication are known, that is, after he is medicated. (This is in contrast to the narrow tailoring component of Weston's bodily integrity claim, which requires a predictive judgment now.) As Judge Tatel stated in the previous panel opinion, "the difficulty inherent in predicting how a particular drug will affect a particular individual may well lead the district court to conclude that it cannot make this determination about Weston without first medicating him. In that event, I see no reason why the potential for side effects would preclude the district court from ordering medication, provided that, should Weston become competent to stand trial, the district court conducts a second hearing to determine the extent to which any side effects Weston is *actually* experiencing might affect his fair trial rights." *Weston*, 206 F.3d at 21 (Tatel, J., concurring). The district court stated that it "will conduct subsequent evidentiary hearings" on this point. *Weston*, 134 F.Supp.2d at 138; see also *United States v. Morgan*, 193 F.3d 252, 264-65 (4th Cir.1999).

### III. Guardian *ad Litem*

Weston also appeals the district court's refusal to appoint a guardian *ad litem*. The district court concluded that it lacked authority to appoint a guardian and expressed uncertainty about what function a guardian would perform if appointed. See 7/24/00 a.m. Tr. at 2-3.

We need not decide whether the court had discretion to appoint a guardian and, if so, whether it abused that discretion in declining to exercise it. The issue is not relevant to the outcome of this case. If the guardian consented on Weston's behalf, the government presumably may medicate him. See Reply Brief for Appellant at 24-25 (stating that a guardian "would effectively stand in Weston's shoes" and that "Weston's counsel also explained at a hearing that a guardian could take the position that the guardian should do as the guardian saw fit with Weston-which would include allowing medication"); see also 7/27/00 a.m. Tr. at 108-09. If the guardian withheld consent, we are in the same position as without a guardian: the government's interest in restoring Weston's competence to stand trial outweighs his liberty interest. If the guardian issue is otherwise relevant, Weston has failed to show it.

\* \* \* \* \*

Because antipsychotic medication is medically appropriate and is necessary to accomplish an essential state policy, the district court's order permitting the government to forcibly medicate Weston is

*Affirmed.*

RANDOLPH, Circuit Judge, with whom Circuit Judge SENTELLE joins, concurring:  
I write separately because I believe *United States v. Weston*, 206 F.3d 9 (D.C.Cir.2000), our first decision in this case, may have embodied a serious error.

Concluding that Weston was not sufficiently dangerous to warrant forcibly medicating him, the panel wrote that "in his current circumstances Weston poses no significant danger to himself or to others." *Weston*, 206 F.3d at 13. This was so because Weston was confined to a room, under constant observation and had no access to anything he could use to harm himself or others. See *id.* The upshot, the panel concluded, was that "[i]f the government advances the medical/safety justification on remand, it will need to present additional evidence showing that either Weston's condition or his confinement situation has changed since the hearing so as to render him dangerous." *Id.*

This standard puts the government in an unnecessary quandary. If Weston were no longer confined to a room and under constant surveillance, he would be dangerous and, presumably, could be medicated. However, because the government cannot medicate him while he is carefully confined-and therefore, not dangerous-it cannot release him into the general pre-trial detention population without incurring substantial risks. The result: the **\*888 \*\*160** government is all but forced to keep Weston in isolation, a condition almost everyone agrees is detrimental to Weston's long-term mental health.

The statutes-18 U.S.C. §§ 4241-4247-provide a far different standard for dangerousness than the prior panel's decision, and represent not only the good judgment of Congress and the President, but also the Judicial Conference of the United States which "after long study by a conspicuously able committee, followed by consultation with federal district and circuit judges," proposed the legislation. *Greenwood v. United States*, 350 U.S. 366, 373, 76 S.Ct. 410, 100 L.Ed. 412 (1956). Under § 4246, a person is to be held and treated if "his release would cause a substantial risk of bodily injury to another person or serious damage to property of another." 18 U.S.C. § 4246(d) (italics added). Thus, the question on Weston's first appeal should not have been whether he was dangerous given the manner in which he was confined, but whether he was dangerous as a general matter, that is, if he were released from strict confinement and observation.

Our concurring colleague proposes a different reading of the prior panel's decision. Because of the problems just discussed, I hope her view eventually prevails even though the language of that opinion, quoted above, does not seem to support her.

ROGERS, Circuit Judge, concurring:  
I write separately on two points: the findings necessary for forcible administration of medication in a pretrial context, and the determination of dangerousness to support such governmental intrusion.

First, following the instruction in *Riggins v. Nevada*, 504 U.S. 127, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992), the court applies a "form of heightened scrutiny," Opinion at 880, in considering a number of factors for balancing the interests of the government and the defendant. Succinctly put, to medicate Weston against his will, "the government must prove that restoring his competence to stand trial is necessary to accomplish an essential state policy." Opinion at 880. The substantive analysis that the court employs encompasses, however, at least three distinct determinations. To allow the government forcibly to medicate a defendant prior to trial with antipsychotic drugs, the district court must find that: (1) an "essential state policy" is at issue, *Riggins*, 504 U.S. at 138, 112 S.Ct. 1810; (2) "treatment with antipsychotic medication [is] medically appropriate and, considering less intrusive alternatives, essential for the sake of [the defendant's] own safety or the safety of others," or essential to enable an adjudication of the defendant's guilt or innocence, *id.* at 135, 112 S.Ct. 1810; and (3) the defendant's due process rights are protected. See *id.* at 137-38, 112 S.Ct. 1810.

The district court on remand made these three determinations. See *United States v. Weston*, 134 F.Supp.2d 115, 138 (D.D.C.2001) ( *Weston III*). On appeal, this court addresses the first

determination under the heading "The Essential State Policy in Adjudicating Criminality." Opinion at 880. It addresses the second and third determinations under the heading of "Involuntary Medication is Necessary and there are no Less Intrusive Means." *Id.* at 882-83. The court provides a separate analysis of each determination. *Id.* at 883-87.

Keeping these determinations separate is important because the Supreme Court has acknowledged that a defendant's liberty interests may outweigh the State's interest. Although indicating that even "a substantial probability of trial prejudice" can be justified if "administration of antipsychotic medication [is] necessary to accomplish an essential state policy," **\*889 \*\*161** *Riggins*, 504 U.S. at 138, 112 S.Ct. 1810, the Court has suggested that the defendant's liberty interests would prevail where, for example, the antipsychotic medication impairs the defendant's "ability to follow the proceedings" or to present a defense. *Id.* at 137, 112 S.Ct. 1810; see also *Drope v. Missouri*, 420 U.S. 162, 171-72, 95 S.Ct. 896, 43 L.Ed.2d 103 (1975); *Pate v. Robinson*, 383 U.S. 375, 378, 86 S.Ct. 836, 15 L.Ed.2d 815 (1966). In such circumstances, the government would have the option of seeking civil commitment of the defendant. See *Riggins*, 504 U.S. at 145, 112 S.Ct. 1810 (Kennedy, J., concurring in the judgment); see generally 18 U.S.C. §§ 4241-4247; D.C.Code 1981 §§ 21-541 to 21-551. For the reasons set forth by the court, the due process concerns relating to evidence of Weston's mental state and to his competency to stand trial are attenuated. See Opinion at 883-87.

Second, the court eschews review of the district court's determination on remand that forced medication was justified because of Weston's dangerousness to himself or others. The court views our decision in *United States v. Weston*, 206 F.3d 9 (D.C.Cir.2000) (per curiam) (*Weston II*) to have "likely precluded" a finding of dangerousness in the absence of evidence that "Weston's condition now exceeds the institution's ability to contain [his dangerousness] through his present state of confinement." Opinion at 879. To suggest that *Weston II* created a "standard" other than the traditional dangerousness standard applicable to pretrial detainees is to misread *Weston II*. See Concurring Opinion at 887-88; see also Opinion at 879; 18 U.S.C. § 4246(d)(2); 28 C.F.R. § 549.43.

The court in *Weston II* did not "put[ ] the government in an unnecessary quandary." Concurring opinion at 887. The court's language must be read in context. In stating that "[i]f the government advances the medical/safety justification on remand, it will need to present additional evidence showing that either Weston's condition or his confinement situation has changed since the hearing so as to render him dangerous," *Weston II*, 206 F.3d at 13, the court was addressing the insufficient evidence of dangerousness in the record before it to support a finding that involuntary medication was "essential" for Weston's safety or the safety of others. See *id.* That evidence showed that as then confined in isolation by the government, Weston did not, in the opinion of the government's treating psychiatrist, pose a significant danger to himself or others. See *id.* What was missing from the district court record was a "searching inquiry into whether less intrusive alternatives [to forced medication] would have been sufficient to control any potential danger posed by Weston to himself and to others." *Id.* at 18 (Rogers, J., concurring in the judgment). The court forewarned, however, that to rely on dangerousness as a basis for forced medication, the government on remand would need to present evidence that showed more than that when confined Weston did not pose a significant danger to himself or others. See *id.* at 13. The government thus remained free to present evidence about the risks of danger that would be created if Weston was not confined in isolation and that less intrusive alternatives to forced medication would be ineffective to control his dangerousness.

The record on remand indicates that the parties and the district court understood what "additional evidence" of dangerousness was required by *Weston II*; none has suggested that the government confronted a "quandary." See Br. for Appellee at 28, 38, 41-42; see also Opinion at 879. Expert medical testimony was offered on Weston's dangerousness in and out of seclusion, distinguishing between Weston's state of mind and his ability to act on his delusions. See, e.g., Test. of Dr. Daniel, **\*890 \*\*162** 4 JA at 27-73. To the point, the government now argues in its brief that Weston's "seclusion from the general population is not an 'alternative' to involuntary medication because it has done nothing to quell [his] dangerous behavior," Br. for Appellee at 42, and that "'prolonged use' of seclusion 'brings risk of detrimental effects to the psychological well-being of the patient,' and is 'inherently aversive.'" *Id.* at 43 (quoting expert medical testimony presented on remand). Hence, the government's "quandary" is a creation of the concurrence.

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U.S. v. Weston  
255 F.3d 873, 347 U.S.App.D.C. 145

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# ADDENDUM C

*United States v. Evans*

LEXSEE 427 F. SUPP. 2D 696

**UNITED STATES OF AMERICA v. HERBERT G. EVANS, JR., Defendant.**

**Case No. 1:02CR00136**

**UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF  
VIRGINIA, ABINGDON DIVISION**

**427 F. Supp. 2d 696; 2006 U.S. Dist. LEXIS 40549**

**April 20, 2006, Decided**

**SUBSEQUENT HISTORY:** Affirmed by *United States v. Evans*, 2006 U.S. App. LEXIS 23263 (4th Cir. Va., Sept. 12, 2006)

**PRIOR HISTORY:** *United States v. Evans*, 404 F.3d 227, 2005 U.S. App. LEXIS 5949 (4th Cir. Va., 2005)

**COUNSEL:** **[\*\*1]** S. Randall Ramseyer, Assistant United States Attorney, Abingdon, Virginia, for United States of America.

Monroe Jamison, Abingdon, Virginia, for Defendant.

**JUDGES:** JAMES P. JONES, Chief United States District Judge.

**OPINION BY:** JAMES P. JONES

**OPINION:**

**[\*697] OPINION AND ORDER**

By: James P. Jones

Chief United States District Judge

In this criminal prosecution, the government has moved for permission to involuntarily medicate the defendant in order to render him competent to stand trial. For the foregoing reasons, and subject to the strict conditions set forth herein, I will grant the government's motion.

**I. BACKGROUND.**

The defendant Herbert G. Evans is charged with forcibly interfering with a United States Department of Agriculture employee and threatening to murder a magistrate judge. Evans suffers from paranoid schizophrenia and it is agreed that he is incompetent to stand trial. Evans has refused antipsychotic medication to restore his competency and in 2003 the government moved for au-

thorization to medicate him involuntarily. After a hearing, and applying the four-part test articulated by the Supreme Court in *Sell v. United States*, 539 U.S. 166, 123 S. Ct. 2174, 156 L. Ed. 2d 197 (2003), I granted the government's **[\*\*2]** motion. *United States v. Evans*, 2004 U.S. Dist. LEXIS 4204, No. 1:02CR00136, 2004 WL 533473 (W.D.Va. Mar. 18, 2004).

Evans appealed, arguing that the first, second, and fourth prongs of *Sell* were unmet. <sup>n1</sup> The Fourth Circuit vacated this court's decision and remanded for further proceedings. *United States v. Evans*, 404 F.3d 227 (4th Cir. 2005). In its opinion, the court of appeals disagreed with Evans regarding *Sell*'s first prong, holding that there was adequate evidence that the government's prosecutorial interest was sufficiently important to involuntarily mediate Evans. *Id.* at 238, 239-240. However, it found erroneous my factual conclusions regarding the second and fourth *Sell* prongs--whether the government had adequately demonstrated that its prosecutorial interest was significantly furthered by involuntary medication, and whether involuntary medication was medically appropriate. It held that the government had failed to articulate with sufficient particularity the medications it planned to administer to Evans, the potential side effects particular to Evans' medical condition, and **[\*698]** a plan for responding to the onset of such side effects. *Id.* at 240-41. **[\*\*3]**

<sup>n1</sup> The third prong, whether medication is necessary, is not at issue here. I originally resolved the necessity requirement in the government's favor, and that finding was not challenged on appeal.

In its opinion, the Fourth Circuit "emphasized that [the *Sell*] principles require an exacting focus on the personal characteristics of the individual defendant and the particular drugs the Government seeks to administer."

*United States v Baldovinos* 434 F 3d 233 240 n 5 (4th Cir 2006) (characterizing *Evans* decision)

Following remand, the government submitted to the court a new forensic evaluation prepared at the Federal Medical Center in Butner, North Carolina ("Butner"). In response to the Fourth Circuit's finding of a lack of specificity, the new evaluation (the "Butner Report") detailed the process by which the government proposed to involuntarily medicate Evans, and included the particular medications and dosages to be used, the methods of administering those drugs, and a treatment [\*\*4] plan for responding to side effects. In reply to the Butner Report, Evans submitted a report co-authored by Margaret S. Robbins, M.D., and Thomas E. Schacht, Psy.D., ("Robbins Report"), which included objections to the course of treatment proposed in the Butner Report and rebutted the analysis regarding the cited literature review. Both reports are summarized in greater detail hereafter.

On February 10, 2006, an evidentiary hearing was held in obedience to the directions of the court of appeals relating to the second and fourth *Sell* prongs. Testifying at that hearing were Byron Herbel, M.D., a psychiatrist at Butner, for the government, and Drs. Robbins and Schacht for the defendant. The parties have timely submitted additional briefing, and the issues are now ripe for decision.

## II THE FORENSIC EVALUATIONS

### *The Butner Report*

I begin by setting out the treatment plan proposed by the Butner Report. Butner proposes treating Evans first with long-acting risperidone (Risperdal Consta), a second-generation antipsychotic medication, to be administered by injection. In order to determine Evans' ability to tolerate risperidone, Butner proposes administering small test doses of [\*\*5] short-acting risperidone over the course of two days: one-half milligram on day one, and one milligram on day two. In administering the initial doses, Butner would first attempt to persuade Evans to ingest the oral doses voluntarily; if he refuses, Butner proposes to restrain Evans, insert a nasogastric tube, and administer the test doses in that manner.

If Evans tolerates the test doses with no adverse reaction, Butner proposes beginning injections of twenty-five milligram doses at two-week intervals, monitoring Evans for therapeutic benefit and medication side effects. Sustained release of the medication would begin approximately four weeks after the initial injection. The report predicts that symptoms would begin to improve after six to eight weeks, though an adequate antipsychotic trial would only be reached after three to four months of continuous treatment. Serum risperidone lev-

els could be obtained to provide guidance for dosage adjustments up to fifty milligrams every two weeks. If after an adequate medication trial Evans' symptoms continue to be resistant, then treatment with a substitute antipsychotic medication should be considered.

The Butner Report provides that during [\*\*6] the risperidone treatment, Evans would be monitored for neuromuscular and metabolic side effects, the latter being more prevalent with second-generation drugs. The report provides a specific plan for administering adjunctive medication to manage any neuromuscular side effects that manifest, [\*\*699] including treatment with an alternative antipsychotic should the side effects persist despite adjunctive treatment. Also during the risperidone treatment, Evans would be monitored for negative effects on his diabetes, using the standard Butner protocols including weighing, body mass index recordings, finger-stick glucose, and serum lipid measure, all on a monthly basis. Evans would also be counseled on relevant lifestyle modifications should side effects arise.

If it became necessary to discontinue the risperidone treatment, the Butner Report suggests a first alternative plan using long-acting haloperidol (Haldol Decanoate) in an injectable form, implementing a similar test dose strategy as with the risperidone treatment. Initially, Evans would be administered test doses of one milligram for two days, either in oral form or through injection, depending on Evans' cooperation. A nasogastric tube is [\*\*7] not indicated for administration of haloperidol. Barring any adverse event following the test doses, Evans would be administered twenty-five milligrams of long-acting haloperidol at two-week intervals. With serum haloperidol monitoring, the dose could be increased not to exceed 150 milligrams in a four-week period.

The Butner Report proposes a second alternative treatment plan, which would require Evans to cooperate consistently with daily ingestion of an alternative second-generation oral antipsychotic medication, aripiprazole, in daily 7.5 milligram doses. After an observation period, the report provides that the dose would be increased by increments of 7.5 milligrams as clinically indicated up to forty-five milligrams daily. A third alternative treatment plan would require Evans' consistent cooperation in ingesting daily doses of second-generation antipsychotic ziprasidone in twenty milligram oral doses daily. After a period of observation, the report provides that the dose could be increased by increments of twenty milligrams up to an eighty milligram dose twice daily.

n2 The Butner Report predicts that Evans' cooperation is unlikely.

[\*\*8]

In addition to the treatment plan and the literature review summarized in more detail below, the Butner Report offered an extended history of Evans' mental health treatment, including two instances of involuntary medication using haloperidol injections in the 1980s, although treatment records noting specific doses and duration are sparse. Other records show that Evans was hospitalized three times at Southwestern State Hospital. In 1976, he received no medication; in 1979, he was treated with Mellaril, though his delusions persisted throughout treatment. In January 1981, Evans took Serenil for four days, but was then forcibly medicated in February with "calmer" results that were recorded only as long as his brief hospitalization. Evans advised that during these hospitalizations, he experienced serious neuromuscular side effects, including drooling, pacing, and jaw locking and characterized the experience as "torture."

In 1984, during Evans' last hospitalization, he was again treated with Mellaril, resulting in minimization of his delusional beliefs. It is the 1984 successful treatment history upon which the Butner Report relies to support its opinion that Evans' symptoms are not [\*\*9] treatment-resistant.

In arguing that the involuntary medication of Evans meets the *Sell* standard, the Butner Report provides a number of empirical data studies indicating a substantial success rate with involuntary medication for patients like Evans. Two studies by Ladds and colleagues support the premise. The Ladds studies involved a [\*\*700] group of sixty-one incompetent pretrial defendants referred for involuntary psychotropic treatment. Of the forty-five who were involuntarily medicated, eighty-seven percent were rendered competent.

The Butner Report also cited guidelines of the American Psychiatric Association ("APA") issued in 2004 for treating schizophrenia, which provide a number of statistics related to treatment of schizophrenia. The guidelines provide that first-episode patients are more responsive to treatment, multi-episode patients are slightly less responsive, and all patients are subject to relapse within one or two years. Ten to thirty percent of patients will have little to no response to treatment, and an additional thirty percent exhibit some response. Factors relevant to Evans that predict poor treatment response include male gender, severe hallucinations and delusions, [\*\*10] history of side effects, and long duration of untreated psychosis. The Butner Report contends that applying the APA guidelines relevant to Evans suggests a probability of competency restoration between ninety percent in the best case and forty percent in the worst case. An additional study provided that group

probabilities do not speak to individual cases given the unpredictability of the illness itself.

The report also cited a study by Lasser, which considered the favorable response of fifty-seven elderly individuals with schizophrenia or a related disorder to treatment with long-acting risperidone. Treatment resulted in significant improvement of symptoms with a "low rate" of adverse side effects.

The Butner Report cited a record review not yet published by Stelmach, involving twenty-one patients with delusional disorder admitted to Butner for competency restoration. Sixteen of the twenty-one were restored to competency after treatment with antipsychotic medication. No patients met the particular profile of Evans.

The report contains a number of additional studies, summaries of which are not necessary here.

The Butner Report offered empirical data rebutting Dr. Robbins' opinion [\*\*11] that Evans' delusions are impervious to medication. While the Butner physicians found no data on patients specifically matching Evans' profile, there was data supporting a more optimistic outcome than that suggested by Dr. Robbins. A study by Tirupati and colleagues described one-year treatment outcomes for forty-nine patients with schizophrenia left untreated for many years. In that case, forty-seven percent of patients having been ill for five years or less had good outcomes, while only six percent of those untreated for over fifteen years had good outcomes. However, the data sample was unlike Evans because Evans has a high level of functioning despite his long history of illness. The report contends that the data from all the studies cited, when viewed in light of the characteristics distinguishing Evans from the study samples and his history of positive response to treatment with medication, indicates that treatment is more likely than not to restore him to competency.

In brief, the Butner Report responds to the Fourth Circuit's remand order by setting out a carefully detailed initial treatment plan followed by a number of alternatives, a plan for monitoring and responding [\*\*12] to side effects generally and related specifically to Evans' medical condition, and a literature review supportive of its position.

#### *The Robbins Report.*

The Robbins Report offered a number of objections to the Butner Report's proposed course of treatment, and offered alternative [\*\*701] analysis regarding the studies cited by that report. Dr. Robbins' arguments are summarized briefly below.

With regard to the specific treatment plan proposed for Evans, Dr Robbins opined that antipsychotic medication is unlikely to restore his competency. She believes that the long duration of his delusions without treatment, when combined with the fact that the substance of Evans' delusions correlates so accurately with his current legal status, results in delusions that would be particularly treatment-resistant. It is also Dr Robbins' position that, when taking all of the relevant factors into account, and in particular the negative factors listed in the APA Practice Guidelines, n3 Evans' delusions are likely impervious to medication. In support of that assertion, Dr Robbins looks to the Tirupati and Silva studies cited by the Butner Report. Tirupati, which does not address delusional patients, shows [\*13] that long duration of untreated psychosis, at least twenty years in Evans' case, produces "dismal" prospects for treatment with medication. Silva's study produced seven delusional patients, none of whom responded to medication.

n3 As detailed above, factors suggesting an unfavorable treatment outcome for Evans include the fact that Evans is male, the long duration of Evans' untreated psychosis, his long-standing negative attitudes about treatment, the severity of his delusions, a history of side effects, and the provision of medication in an adversarial context.

In response to the government's contention that the 1984 positive treatment response proves that Evans' delusions are not impervious to medication, Dr Schacht testified that when the medical history is viewed as a whole, one observes many more instances in which medication was not successful in treating Evans' symptoms. Further, Dr Schacht indicated that "fair remission," as indicated in the treatment notes, does not necessarily correlate with other [\*14] treatment notes indicating persistent delusions, and has no consistent medical meaning.

Dr Robbins did not offer objections to the particular medications prescribed in the Butner Report, although she strongly opposed the use of a nasogastric tube for the administration of the test doses. Both Dr Robbins' report and her testimony at the hearing indicated that the risks involved in inserting a nasogastric tube, particularly on an uncooperative, combative patient, far outweighed its possible benefits. Dr Robbins recommended that a test dose be administered in a soluble tablet form, which dissolves immediately upon contact with a moist surface and provides minimal risk of harm to an uncooperative or combative patient.

The Robbins Report also criticizes the particularity with which the Butner treatment plan proposes to re-

spond to side effects relating to Evans' high blood pressure and diabetes, particularly in light of the fact that side effects most prevalent with second-generation antipsychotics, like risperidone, are metabolic in nature. The proposed treatment plan provides in general terms that it will monitor for side effects using a standard protocol, and will refer Evans to [\*15] medical management should his diabetes worsen. However, Dr Robbins points out that the plan fails to set out the specific conditions which, if reached, would or should result in discontinuing treatment or other measures. n4

n4 For example, the Robbins Report queries the specific actions to be taken should Evans' diabetic condition, currently managed by oral medication, worsen to the point of requiring daily insulin injections.

The Robbins Report further criticizes the treatment plan's lack of specificity regarding [\*702] a response to negative side effects relating to Evans' hypertension. Particularly, the report's concerns are based on the potential for low blood pressure caused by simultaneous treatment with risperidone and Evans' antihypertensive medication. Also criticized is the Butner Report's failure to consider the possibility of increased hypertension induced by stressful encounters related to Evans being medicated against his will.

The Robbins Report also critiques the Butner Report's statements regarding [\*16] possible side effects caused by treatment with antipsychotic medication. With regard to the Lasser study involving the use of long-acting risperidone on elderly patients, Dr Robbins points to the fact that while the study reports a "low rate" of side effects, that rate is never explicitly quantified in the report. Dr Robbins contends that the court should reach its own conclusion regarding whether the side effect incidence in Lasser was, in fact, low. Further, Dr Robbins contends that Evans is distinguishable from the patients included in the Lasser study because, in relevant part, those patients had been previously stabilized on oral risperidone for at least two weeks. According to Dr Robbins, the Lasser study speaks most clearly about patients who, unlike Evans, have already tolerated and benefited from voluntary treatment with antipsychotic medication. The report also states that, generally, the possibility of side effects capable of hindering Evans' defense cannot be adequately predicted in advance.

Generally and in response to the literature review proffered by the Butner Report, the Robbins Report and related hearing testimony assert that the individuals included in the [\*17] group research studies cited by the Butner Report lack important similarities to Evans' par-

ticular diagnosis and symptoms, namely that Evans carries a delusional diagnosis rather than a diagnosis of generalized schizophrenia. Additional factors lacking from group research are Evans' long duration of untreated psychosis, long-standing negative attitudes toward treatment, and the administration of medication in an adversarial manner. Further, the report disputes the Butner Report's equation of "positive treatment response" with "restoration of competency," arguing that medicating Evans may result in positive responses, e.g., reduction in agitation, that have no impact on his overall competency.

With respect to the particular reports cited, the Robbins Report rebutted the Butner Report's conclusions regarding the Ladds studies, noting a lack of comparison to a control group, lack of report on the duration of untreated psychosis, and an inflated success rate, among other criticisms. Dr. Schacht's testimony at the hearing offered a similar criticism. The Robbins Report offers additional specific critiques to each of the studies cited by the Butner Report, which I will not detail here. [\*\*18]

On the whole, Dr. Robbins believes that antipsychotic medication is unlikely to return Evans to competency, and that the *Sell* prongs therefore cannot be met.

I next review the evidence in light of the legal standard articulated by the Supreme Court and make the necessary findings of fact.

### III. ANALYSIS.

#### *Sell v. United States.*

In *Sell v. United States*, 539 U.S. 166, 123 S. Ct. 2174, 156 L. Ed. 2d 197 (2003), the Supreme Court clarified the legal standard the government is required to meet in seeking the involuntary medication of a defendant for the purpose of rendering the defendant competent to stand trial. It [\*703] held that the government may involuntarily medicate a defendant so long as (1) the government prosecutorial interest is "important," (2) involuntary medication will "significantly further" that interest, (3) involuntary medication is necessary to further that interest, and (4) involuntary medication is "medically appropriate." *Id.* at 180-81. While the Supreme Court in *Sell* failed to articulate a standard of proof to govern consideration of this sort of claim, the parties do not seriously dispute that the appropriate standard requires the government to prove its [\*\*19] case by clear and convincing evidence. Accordingly, I will evaluate the government's case under that standard.

Pursuant to the Fourth Circuit's remand, only the second and fourth prongs are relevant to these proceedings. I will review each in turn.

#### "Significantly Further."

*Sell*'s second prong requires the government to show that involuntary medication will "significantly further" its prosecutorial interest. Involuntary medication "significantly furthers" the government's prosecutorial interest when it is (1) substantially likely to render the defendant competent to stand trial and (2) substantially unlikely to produce side effects that will significantly interfere with the defendant's ability to assist his counsel at trial, thereby rendering the trial unfair. *Id.* at 181.

After carefully reviewing the record in this case, I find that involuntary medication is substantially likely to render Evans competent to stand trial, and is substantially unlikely to produce side effects that will significantly interfere with Evans' defense.

I find persuasive a number of factors contained in the Butner Report. The Ladds study, finding an eighty-seven percent return to competency [\*\*20] by those forcibly medicated, is compelling evidence regarding the probability of restoring Evans' competency in this case. Also persuasive is Dr. Herbel's opinion that Evans' 1984 positive response to antipsychotic medication n5 after twenty years of no treatment suggests that Evans may reasonably be expected to have a similar outcome when treated again with antipsychotic medication. Relatedly, I find convincing Dr. Herbel's opinion that Evans' high level of functioning suggests that, notwithstanding his years without treatment, he has not suffered a decreased response thereof, and that, in his own day-to-day experience, a patient's negative view of medication is not associated with a decreased response to treatment. n6

n5 The record indicates that in 1984, Evans was forcibly medicated with a relatively low dose of antipsychotic medication, and that the medication was successful in restoring his competency.

n6 At the hearing, Dr. Herbel testified that he had personally been involved in eighty involuntary medications, although the majority were medicated absent the use of force. Dr. Herbel recalled twenty-two incidents in the last calendar year requiring the use of force for involuntary medication, of which seventy-seven percent resulted in competency restoration. No forced medication in the past year, and only one forced medication in thirteen years resulted in an injury to the patient.

[\*\*21]

Taking all of the factors into consideration, Dr. Herbel opined that Evans maintained an estimated seventy to eighty percent chance of being restored to competency.

Dr. Robbins, testifying on behalf of Evans, admitted that even though she believes it unlikely that medication will restore Evans to competency, involuntary medication for the purpose of restoring competency is appropriate in some situations. I find that Dr. Herbel's opinion, [\*704] when considered in light of the evidence and scientific studies produced in the Butner Report, presents clear and convincing proof that Evans is substantially likely to be restored to competency for trial purposes.

I also find clear and convincing evidence to support the government's assertion that involuntarily medicating Evans is substantially unlikely to produce side effects rendering him incapable of assisting in his defense. While it is apparent from the literature cited by the Butner Report that troublesome side effects, mainly metabolic in nature, are common with second-generation antipsychotics, they generally are not so serious as to inhibit Evans' assistance with his own defense. During treatment, Evans' high blood pressure and diabetes [\*\*22] will be closely monitored, but do not add to the risk of nor enhance the severity of side effects. Neither does there appear to be a strong risk that the subject matter and deep-seeded nature of Evans' delusions will significantly interfere with his defense despite treatment. Further, the treatment plan proposed by Butner consistently calls for close monitoring of Evans' response to the drugs, as evidenced by the use of test doses, serum level testing, and commitment to using the lowest effective dose.

Accordingly, after taking into consideration all of the evidence presented in the reports and at the evidentiary hearing, I find that the government has met its burden with respect to Sell's second prong, namely, that involuntary medication of Evans will significantly further its prosecutorial interest.

*"Medically Appropriate."*

Sell's fourth prong requires a finding that involuntary medication is medically appropriate, or in the best interest of the patient in light of his medical condition. *Sell*, 539 U.S. at 181. *Sell* counseled that a court should consider the specific kind of drug administered, its side effects, and its levels of success. *Id.*

The Butner [\*\*23] Report specifically considers whether involuntary medication is medically appropriate under the circumstances and reaches an affirmative conclusion that it is appropriate. In support, the Butner Report included an article by Lasser, detailing a study of favorable treatment response of long-acting risperidone on fifty-seven elderly patients with schizophrenia. Treatment resulted in a low rate of adverse side effects caused by the medicine.

Further, as described in detail above and in accordance with the Fourth Circuit's remand, *see Evans*, 404 F.3d at 242, the Butner Report proposes in clear, careful detail a primary course of treatment with three alternatives, an estimated length of time after which Evans' competency would be restored, criteria to be used in determining when treatment should be discontinued, a plan for monitoring for possible side effects specific to Evans' condition and medical history, and an explanation of the benefits and costs of such treatment. I find, with two exceptions explained below, that the government's contention that the proposed course of treatment is medically appropriate is supported by clear and convincing evidence.

Dr. Herbel reported [\*\*24] that antipsychotic medication "is the only intervention that will be likely to restore [Evans'] competency to stand trial." (Tr. at 46.) Because Evans' has expressed an intent to be uncooperative with medication, the Butner Report chose a long-acting antipsychotic, risperidone, in order to reduce the necessity for forceful encounters with Evans in administering the medication. A second-generation antipsychotic was chosen for the first course of treatment in order to avoid the neuromuscular side effects Evans [\*705] experienced previously with exposure to haloperidol, though both psychiatrists at the hearing testified that the past side effects were likely caused by overdosing. Risperidone is the only second-generation antipsychotic available in a long-acting form.

As to treatment duration, Dr. Herbel testified at the evidentiary hearing that Evans would need to be treated with an antipsychotic medication for between four and five months in order to restore him to competency. If Evans failed to respond within five months, the government would seek leave to begin administering an alternative antipsychotic medication for an additional four to five months. Treatment would be discontinued [\*\*25] either after two five-month treatment cycles with two separate antipsychotics followed by no improvement in Evans' condition, or earlier with the onset of intolerable side effects.

As detailed above, the Butner Report clearly sets out the side effects that may potentially arise with the use of antipsychotic drugs, and describes a specific plan to be carried out in monitoring Evans' response to the drugs. Because second-generation antipsychotics produce metabolic side effects that could potentially affect Evans' blood sugar and high blood pressure, both would be closely monitored during his treatment. Risk of such side effects is reduced due to the fact that the Butner Report ruled out using those second-generation antipsychotic drugs with the highest propensity for metabolic side effects. Onset of any side effects would be addressed through a doctor-patient meeting and possible drug substi-

tution. Taken in total, I find that the government's proposals are medically appropriate and supported by clear and convincing evidence.

The government has failed to meet its burden with regard to the proposed use of a nasogastric tube for administration of test doses. The Butner Report and testimony [\*\*26] at the hearing propose restraining Evans and inserting a tube through his nose into his stomach, and administering small, short-acting doses of antipsychotic medication as a means of gauging Evans' tolerance of the drug. While sound reasoning supports the administration of test doses of risperidone prior to use of the long-acting version, the medical appropriateness of using a tube for that purpose is not supported by clear and convincing evidence. Risks involved in inserting the tube include accidental passage into the pulmonary tract and perforation of the esophagus, all of which are more likely in patients, like Evans, who are uncooperative during insertion. Dr. Robbins characterized the risks as "life-threatening" at the evidentiary hearing. (Tr. at 136.) Medical appropriateness is made more questionable in light of the fact that risperidone appears to be available in an orally disintegrating tablet form.<sup>n7</sup> The risks associated with the use of a nasogastric tube outweigh the benefits of treatment in this case. Accordingly, because the government has failed to meet its burden of proof on this issue, I find that the test doses of risperidone must be administered in soluble tablet [\*\*27] form instead of by a nasogastric tube.

<sup>n7</sup> Risperdal M-Tab(R). See [http://www.risperdal.com/html/ris/consumer/pd\\_risperidone.xml?article=dosing.jspf](http://www.risperdal.com/html/ris/consumer/pd_risperidone.xml?article=dosing.jspf).

The government has also failed to meet its burden with regard to its proposed response to a worsening of Evans' diabetes. Currently, Evans' diabetes can be managed with daily oral medication, which Evans takes voluntarily. While the Butner Report sets out a means of monitoring [\*\*706] Evans' glucose and insulin levels and generally takes into consideration the potential for a worsening of Evans' diabetes, the report fails to provide in adequate detail the actual steps to be taken should Evans' diabetes in fact worsen, particularly to the point of requiring daily insulin shots. I do not find clear and convincing evidence that the current treatment plan is medically appropriate with regard to a worsening of Evans' diabetes. Accordingly, because the government has failed to meet its burden of proof on this issue, I will direct that, in the event that Evans' diabetes worsens [\*\*28] to the point of requiring daily insulin shots, the government must cease treatment with the antipsychotic

currently in use and return to this court with a new proposal.

#### IV. CONCLUSION.

For the foregoing reasons and pursuant to the following conditions, the government's motion to involuntarily medicate Evans is GRANTED. It is ORDERED that the government may involuntarily medicate Evans in an effort to restore him to competency subject to the following conditions:

1. The government may initiate treatment with risperidone pursuant to the dosing schedule provided in its proposed treatment plan:

- a. The government may administer test doses of short-acting risperidone;

- b. The government must not administer test doses using a nasogastric tube, but may use short-acting risperidone only in an oral form or in a soluble tablet form;

- c. If Evans tolerates the test doses, the government may administer long-acting risperidone by injection pursuant to the dosing schedule provided in its proposed treatment plan for no longer than five months.

2. If risperidone test doses are unable to be given, or if risperidone treatment fails due to lack of effect on symptoms [\*\*29] or the onset of intolerable side effects, the government may treat Evans with haloperidol:

- a. The government may administer test doses of short-acting haloperidol in the oral or injectable forms;



b. If Evans tolerates the test doses, the government may administer long-acting haloperidol by injection pursuant to the dosing schedule provided in its proposed treatment plan for no longer than five months;

3. If haloperidol treatment fails due to the onset of intolerable side effects, the government may initiate treatment with aripiprazole pursuant to the dosing schedule set out in its treatment plan.

4. If aripiprazole treatment fails due to the onset of intolerable side effects, the government may initiate treatment with ziprasidone pursuant to the dosing schedule set out in its treatment plan.

5. The total course of treatment must not last longer than ten months; after ten months, all antipsychotic medication must

cease and the government must return to this court with a new proposal.

6. The government must monitor Evans for neuromuscular, metabolic, and other side effects during all treatment, and, in particular, for side effects related to his diabetes [\*\*30] and hypertension.

7. If at any time during treatment Evans' diabetes reaches a level requiring daily insulin injections, all antipsychotic medication must cease and the government must return to this court with a new proposal.

[\*707] 8. The government must not deviate from its proposed treatment plan or from the directions set forth above without first obtaining permission of this court.

ENTER: April 20, 2006

/s/ JAMES P. JONES

Chief United States District Judge

# ADDENDUM D

*United States v. Algere*

LEXSEE 396 F. SUPP. 2D 734

## UNITED STATES VERSUS LAWRENCE ALGERE

## CRIMINAL ACTION NO. 03-86 SECTION "R"

UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF  
LOUISIANA*396 F. Supp. 2d 734; 2005 U.S. Dist. LEXIS 33167*

July 1, 2005, Decided

July 5, 2005, Filed

**COUNSEL:** **[\*\*1]** For Lawrence Algere (1), Defendant: Gary V. Schwabe, Jr., Federal Public Defender, New Orleans, LA.

For United States of America, Plaintiff: Gregory M. Kennedy, U. S. Attorney's Office, New Orleans, LA.

**JUDGES:** SARAH S. VANCE, UNITED STATES DISTRICT JUDGE.

**OPINION BY:** SARAH S. VANCE

**OPINION:**

**[\*736] ORDER AND REASONS**

Before the Court is the government's second motion for authorization to involuntarily medicate defendant Lawrence Algere with antipsychotic drugs to restore his competency to proceed to trial. For the following reasons, the Court GRANTS the government's motion.

**I. FACTS AND BACKGROUND**

On April 4, 2003, defendant Algere was indicted for a violation of *18 U.S.C. § 922(g)*, possession of a firearm by a convicted felon. On May 9, 2003, on a joint motion from the government and Algere, the Court appointed a licensed psychologist, Dr. Emily Fallis at the Federal Medical Center at Fort Worth, Texas, to evaluate Algere and provide the Court with a written opinion as to his competency to stand trial and his sanity at the time of the alleged offense.

On September 5, 2003, the resulting written report diagnosed Algere with Schizophrenia, Undifferentiated **[\*\*2]** Type, which is characterized by at least a one-month period in which two or more of the following occur: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative

symptoms (e.g., emotional flattening and poverty of speech). In Dr. Fallis's opinion, Algere was not competent to stand trial. On September 22, 2003, the Court held a competency hearing under *18 U.S.C. §§ 4241* and *4247*, at which counsel for the government, counsel for the defense and the defendant were all present. Based on the evidence received, the Court found Algere not competent to stand trial by a preponderance of the evidence and ordered that he be committed to the custody of the Attorney General for treatment under *18 U.S.C. § 4241(d)*. The Court also ordered that another written opinion as to Algere's competency be prepared after the treatment. Algere was admitted to the Federal **[\*737]** Medical Center, Mental Health Department, in Butner, North Carolina.

On August 4, 2004, Dr. Carlton Pyant, a licensed psychologist, and Dr. Bruce P. Capehart, a licensed psychiatrist at the FMC, submitted a written report reporting Algere's progress **[\*\*3]** and evaluating his condition in accordance with the Court's order. Pyant and Capehart diagnosed Algere with Schizophrenia, Paranoid Type. (Rep. of 8/4/04 at 5-6). The doctors noted that paranoid ideation and marked disorganization dominated the majority of Algere's conversations and that he was intensely focused on identifying and preparing for conflict with his enemies. (*Id.* at 3-4). He was also concerned about contracting diseases from his food. (*Id.* at 5). Algere also displayed delusions about the criminal justice system, stating that he wishes to plead "not guilty with conflict of interest" meaning "statements they have against you are not valid." (*Id.* at 7). Dr. Pyant testified that Algere agreed to take Abilify less than five times and then refused it because he did not like how he felt on the medication, although no objective observations indicated the presence of any side effects. The doctors concluded that, without treatment with antipsychotic medication, Algere remained incompetent to stand trial. (*Id.* at 6).

Because Algere continued to refuse antipsychotic medication on a voluntary basis, on August 19, 2004, the government moved to authorize the FMC to medicate [\*\*4] Algere involuntarily with antipsychotic drugs under the Supreme Court's decision in *Sell v. United States*, 539 U.S. 166, 123 S. Ct. 2174, 156 L. Ed. 2d 197 (2003). On October 14, 2004, the Court denied the government's motion because there was no evidence that the procedures of 28 C.F.R. § 549.43 had been followed. That section requires that the determination of whether it is necessary to forcibly medicate an inmate because he is dangerous to himself or others in his current environment or to render him competent to stand trial be made in the context of an administrative hearing. n1 The inmate must be given twenty-four hour advance written notice of the hearing and be afforded the right to appear at the hearing, to present evidence, to be represented by a staff member, and to request that witnesses be questioned. 28 C.F.R. § 549.43(a)(2).

n1 It appears to be the Bureau of Prisons' position that, after *Sell*, this administrative hearing procedure is no longer valid when the medication is to be administered involuntarily solely for the purposes of restoring competency for trial. See *United States v. Barajas-Torres*, 2004 U.S. Dist. LEXIS 13232, No. CRIM.EP-03-CR-2011KC, 2004 WL 1598914, at \*1 n.2 (W.D. Tex. July 1, 2004). The procedure was necessary in this case, however, because there had not been any administrative determination regarding Algere's dangerousness, which *Sell* requires a court to consider before it authorizes involuntary medication on other grounds. 539 U.S. at 181-82. The determination of an inmate's dangerousness involves prison administration and is probably better made by prison authorities and medical professionals most familiar with the inmate through frequent and ongoing clinical observation. See *Washington v. Harper*, 494 U.S. 210, 223-34, 231, 110 S. Ct. 1028, 108 L. Ed. 2d 178 (1990).

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The administrative hearing was held on November 11, 2004 and resulted in an administrative determination that involuntary medication was not warranted on the ground that Algere was dangerous to himself or others at the FMC, in large part because he is safely housed in a single cell in a restricted unit. (Involuntary Medication Rep. of 12/2/04 at 7-10). The government does not challenge the determination that Algere is not dangerous to himself or other in his current environment. Algere remains confined at the [\*738] FMC, no anti-psychotic

drugs have been administered, and he remains incompetent to stand trial.

The government now moves for a second time that the Court order that Algere be involuntarily medicated to render him competent to stand trial. The Court scheduled a hearing on the government's motion and ordered that the government submit a supplemental report addressing several specific issues regarding the proposed treatment. The Court held a hearing on June 29, 2005, at which the Court heard testimony from Dr. Pyant and Dr. Jean Zula, the chief psychiatrist at FMC, who are both familiar with Algere's case.

The report indicates, and Dr. Pyant testified, that Algere's thinking and [\*\*6] speech are consistently disorganized, and he continues to express fears about being physically harmed by others. On 2/23/05, for example, Algere reported suffering from a knee injury caused by someone entering his cell and attacking him while he slept. (Forensic Addendum of 6/10/05 at 3). He also thinks that the judge is working against him, and he feels "mistreated by the Court." (*Id.* at 3-4). Algere fears being "locked up on falsified legal documents." (*Id.* at 3). He displays behavioral disorganization such as wearing strips of cloth around his limbs because "you never know when someone will come up and shank you." (*Id.* at 3-4). Finally, Algere has expressed that he refuses to take antipsychotic medication because he fears: (1) being convicted of murder; (2) being vulnerable to his enemies; and (3) getting the death penalty. (*Id.* at 4). Based on the evidence produced at the hearing, the Court rules as follows.

## II. DISCUSSION

### A. Applicable Law

An individual has a constitutionally protected liberty interest in rejecting medical treatment. See *Washington v. Harper*, 494 U.S. 210, 211, 110 S. Ct. 1028, 108 L. Ed. 2d 178 (1990) (recognizing "a significant liberty interest [\*\*7] in avoiding the unwanted administration of antipsychotic drugs"); *Riggins v. Nevada*, 504 U.S. 127, 134, 112 S. Ct. 1810, 118 L. Ed. 2d 479 (1992) (repeating that there is a constitutionally protected "interest in avoiding involuntary administration of antipsychotic drugs"). Such medication may be forcibly administered, however, in certain circumstances. In *Harper*, for example, the Supreme Court held that administering anti-psychotic drugs against a prison inmate's will does not violate the *Due Process Clause* "if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest." *Harper*, 494 U.S. at 227. Here, however, the administrative hearing resulted in a determination that forcibly medicating Algere is not warranted on dangerousness grounds under *Harper* because Algere is not dangerous

to himself or others in his current prison environment. The government does not challenge that determination. Accordingly, it is undisputed that this request involves the involuntary administration of medication to a non-dangerous defendant solely for the purposes of restoring him to competency for trial, which places it squarely within the standard set forth [\*\*8] by the Supreme Court in *Sell v. United States*, 539 U.S. 166, 123 S. Ct. 2174, 156 L. Ed. 2d 197 (2003).

In *Sell*, the Court concluded that the government may involuntarily administer anti-psychotic drugs "to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial" if certain conditions are met. *Id.* at 179. Such treatment is authorized only if it "is medically appropriate, is substantially unlikely to have side effects that may undermine [\*\*739] the fairness of the trial, and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests." *Id.* The Court indicated that this standard requires consideration of four factors: (1) whether important governmental interests are at stake; (2) whether involuntary medication will significantly further those interests; (3) whether involuntary medication is necessary to further those interests; and (4) whether the administration of the drugs is medically appropriate. *Id.* at 180-81. Although the Court did not address the standard by which the Government must establish these factors, at least one other circuit [\*\*9] has concluded that the government must present clear and convincing evidence. *United States v. Gomes*, 387 F.3d 157, 160 (2d Cir. 2004).

## B. Analysis

### 1. Important Government Interest

The first prong of the *Sell* test requires the Court to "find that important governmental interests are at stake." *Sell*, 539 U.S. at 180. There is no question that "the government's interest in bringing an individual accused of a serious crime to trial is important." *Id.* At the same time, however, special circumstances "may lessen the importance of that interest." *Id.* For example, the defendant's refusal to take drugs voluntarily may result in lengthy civil confinement in an institution for the mentally ill, which diminishes the risks usually present in releasing a person who has committed a serious crime. *Id.* Similarly, the length of time the defendant has already been confined, for which he would receive credit toward any sentence imposed, might lessen the government's interest in prosecuting him. *Id.*; 18 U.S.C. § 3585(b). Finally, the government also has an interest in ensuring that the defendant receives a fair [\*\*10] trial. *Sell*, 539 U.S. at 180.

To determine whether a crime should be considered "serious" for the purpose of forcible administration of medication to restore competency, other courts have

looked to jurisprudence on the *Sixth Amendment* right to a jury trial. See *United States v. Evans*, 404 F.3d 227, 237 (4th Cir. 2005); *United States v. Leveck-Amirmokri*, 2005 U.S. Dist. LEXIS 7610, No. EP-04-CR-0961-DB, 2005 WL 1009791, at \*4 (W.D. Tex. Mar. 10, 2005). Those precedents indicate that offenses for which a defendant may be sentenced to more than six months imprisonment are considered serious enough to invoke the right to a jury trial. See *Baldwin v. New York*, 399 U.S. 66, 71, 90 S. Ct. 1886, 26 L. Ed. 2d 437 (1970). Most courts which have considered whether an offense is "serious" in the context of forcible medication have also followed the recent focus in the jury trial cases on the maximum penalty that can be imposed for the offense, rather than the defendant's probable sentencing guideline range. See *Evans*, 404 F.3d at 237 (basing determination as to seriousness of offense on maximum penalty defendant faced if convicted); *Leveck-Amirmokri*, 2005 U.S. Dist. LEXIS 7610, 2005 WL 1009791, at \*4 [\*\*11] (same); *United States v. Kimball*, 2004 U.S. Dist. LEXIS 26586, No. CR03-1025, 2004 WL 3105948, at \*3 (N.D. Iowa Mar. 23, 2004) (same). But see *United States v. Barajas-Torres*, 2004 U.S. Dist. LEXIS 13232, No. CRIM.EP-03-CR-2011KC, 2004 WL 1598914, at \*2-3 and n.4 (W.D. Tex. July 1, 2004) (finding right to jury trial precedent inapplicable in the context of forcible medication because different interests are involved in the two analyses and that "the more accurate reflection of the seriousness of an offense given the fact-specific analysis required by *Sell* would be the relevant guideline range").

[\*740] Algere is charged with possession of a firearm by a convicted felon, a felony carrying a maximum term of imprisonment of ten years. The Court concludes that this is a "serious" offense. See *Evans*, 404 F.3d at 238 (concluding that a felony with a maximum term of imprisonment of ten years is a serious offense "under any reasonable standard"). But see *United States v. Dumeny*, 295 F. Supp. 2d 131, 132-33 (finding that charge under 18 U.S.C. § 922(g)(4) for possession of firearm by a person previously committed to a mental health institute, which carries [\*\*12] a maximum penalty of ten years, not sufficiently serious to warrant forcible medication because there was no indication of violence in defendant's past). The particular circumstances of Algere's offense and his criminal history support the Court's conclusion that the offense is a serious one that the government has an important interest in prosecuting. Algere was previously convicted for manslaughter, a violent offense. Previously convicted criminals are prohibited from possessing guns to reduce the risk to society that they will engage in violent acts. See *U.S. v. Dillard*, 214 F.3d 88, 94 (2d Cir. 2000). In light of the risk Algere's conduct presents to society, particularly considering that he has committed a violent crime in the past, and the penalty he faces if convicted, the Court finds that he is

charged with a serious crime. Accordingly, the Court concludes that the government has an important interest in bringing Algere to trial.

The Court must also consider whether special circumstances, such as the potential for a lengthy term of civil commitment that may result from failure to take medication voluntarily and the period of confinement for which the defendant [\*\*13] would be given credit if convicted, lessen the importance of the government's interest in this case. *Sell*, 539 U.S. at 180. Civil commitment "may mean lengthy confinement in an institution . . . that would diminish the risks that ordinarily attach to freeing without punishment one who has committed a serious crime." *Id.* At the hearing, the doctors did not provide an opinion about whether Algere would be a prospect for civil commitment under 18 U.S.C. § 4246 if he were not medicated, indicating that they would have to first conduct a risk assessment. n2 Even if Algere were a prospect for civil commitment, however, the Court finds that this factor does not completely undermine the government's strong interest in bringing Algere to trial on the serious offense with which he has been charged. *See id.* ("The potential for future confinement affects, but does not totally undermine, the strength of the need for prosecution.").

n2 After a defendant who is judged mentally incompetent to stand trial has been treated for a reasonable period of time, the Court may determine that the defendant's mental condition has not so improved as to permit the trial to proceed. 18 U.S.C. § 4241. In that case, the defendant is subject to the provisions of 18 U.S.C. § 4246. Under that section, if the director of the facility in which the defendant is hospitalized certifies that the defendant is suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another, the defendant may be committed to the custody of the Attorney General. The Attorney General releases the defendant to the appropriate official of the State in which the defendant is domiciled, or, if no State will accept responsibility, to a suitable facility for treatment until (1) such a State will assume such responsibility; or (2) the defendant's mental condition is such that his release, or his conditional release under a prescribed regimen of medical, psychiatric, or psychological care or treatment, would not create a substantial risk of bodily injury to another person or serious damage to property of another. *Id.*

[\*741] As for Algere's period of confinement, he was arrested on March 25, 2003 and has been confined about 27 months. The government and the defense agree that Algere, based on his criminal history and the crime he committed, faces a likely guideline range of 41 to 51 months if convicted after a trial, or 30 to 37 months if he pleads guilty and receives a three-level reduction for acceptance of responsibility. The Court has not seen a presentence report to be able to assess conclusively what Algere's sentence would be under either scenario. Dr. Zula testified that the proposed treatment regimen would take at least four months to restore Algere to competency, and defense counsel estimated that he might require an additional month or two at most to prepare the case for trial, adding approximately six months to Algere's confinement. Although the total length of Algere's confinement is within counsels' estimated guideline range for Algere's sentence if he pleads guilty, the likelihood of which is unknown at this time, the Court again finds that this fact does not completely undermine the government's interest in prosecuting Algere. *See id.* Although these special circumstances may lessen [\*\*15] the government's interest in prosecuting Algere, they do not override it, particularly considering the serious potential consequences of Algere's crime and his criminal history. Accordingly, the Court concludes that the government has an important interest in bringing Algere to trial on the crime with which he is charged.

## 2. Significantly Furthers the Government's Interest

The second prong of the *Sell* test requires the Court to conclude that "involuntary medication will *significantly further*" the government's interest. 539 U.S. at 181 (emphasis in original). To do so, the Court must find that administration of the drugs is both "substantially likely to render the defendant competent to stand trial," and is "substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense." *Id.* Courts have found that a 70 percent probability is sufficient to find a substantial likelihood that an anti-psychotic medication will restore a defendant to competency, but that a ten percent probability is not. *Gomes*, 387 F.3d at 161-62 (70 percent sufficient); [\*\*16] *United States v. Morris*, 2005 U.S. Dist. LEXIS 38785 at \*13, No. CR.A.95-50-SLR, 2005 WL 348306, at \*3 (D. Del. Feb. 8, 2005) (same); *United States v. Ghane*, 392 F.3d 317, 320 (8th Cir. 2004) (five to ten percent chance of restored competence not a substantial likelihood). To satisfy its burden on this element, the government must also "set forth the particular medication, including the dose range, it proposes to administer to [the defendant] to restore his competency." *Evans*, 404 F.3d at 241. This is required "because *Sell* requires an evaluation of possible side effects,

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and different atypical anti-psychotics will have different side effect profiles." *Id.* at 240 (citing *Sell*, 539 U.S. at 185 ("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.")). Finally, the government must demonstrate that "the proposed treatment plan, *as applied to this particular defendant*, is 'substantially likely' to render the defendant competent [\*\*17] to stand trial and 'substantially unlikely' to produce side effects so significant as to interfere with the defendant's ability to assist counsel in preparing a defense." *Id.* at 242 (emphasis in original); see also *United States v. Miller*, 292 F. Supp. 2d 163, 164 [\*742] (*D. Maine* 2003) (holding that adequate consideration must be given "to the question of likely side effects to this Defendant") (emphasis in original).

Here, the government has set forth a proposed course of forcible treatment with injectable short-acting Haldol, a first-generation antipsychotic medication, at a dose of 5-10 mg per day. (Forensic Addendum of 6/10/05 at 15). Although the doctors' treatment preference is to administer Abilify, a second-generation antipsychotic medicine, at an initial dose of 20-25 mg per day, Abilify is not available in injectable form and therefore cannot be administered involuntarily. (*Id.*). The dose of Haldol would be started at the low end of the range and gradually increased to the target range to minimize the chance that side effects will emerge. (*Id.*). Any side effects would be detected and managed through monitoring, adjustment of the dosage, [\*\*18] switching medications, or adding a medication to reduce the side effects. (*Id.* at 10, 12).

#### **a. Substantially Likely to Render Defendant Competent to Stand Trial**

Algere's doctors testified that treatment with antipsychotic medication such as Haldol is the primary treatment for Algere's particular condition and is substantially likely to restore Algere to competence. Dr. Zula's opinion regarding the chances of restoring Algere to competence with medication is based on three sources. First, Dr. Zula cited her experience with medicating patients involuntarily at the FMC, many of them schizophrenic, which has a 70-80% success rate of restoring them to trial competence. Second, Dr. Zula referred to a study of involuntarily medicated felony defendants in New York, most of whom had schizophrenia, which found that 93 percent of those medicated had an unequivocally good response to the medication and that 87 percent were restored to competency, often with first generation antipsychotics such as Haldol. (See Literature Review, revised 6/20/05 at 2). Finally, Dr. Zula noted that the American

Psychiatric Association's "Practice Guideline for the Treatment of Patients with Schizophrenia" [\*\*19] indicates that more than 70 percent of first-episode schizophrenics achieve remission of psychotic signs within three to four months with antipsychotic medication, and 83 percent achieve stable remission at the end of one year. (*Id.* at 4). Medication does not always work, of course. According to the Guidelines, ten to 30 percent of patients have little or no response to antipsychotic medication. (*Id.*). Dr. Zula admitted that males are generally less responsive to treatment and that Algere's resistance to being medicated might affect his treatment response, but she also noted that the New York study and the FMC's success rate are all based on the administration of antipsychotic medicine to men. Based on the data and her own successful experiences, Dr. Zula maintained her opinion that treatment with antipsychotic medication generally and Haldol specifically is substantially likely to restore Algere to trial competence.

In addition, the doctors opined, based on published studies that antipsychotic medications can reduce apathy, improve cognition and improve a patient's insight into the fact that he is suffering from a psychotic illness, all of which are relevant to the restoration [\*\*20] of competency. (Forensic Addendum at 7-8). Further, Dr. Zula testified that even if the antipsychotic medication only partially treated Algere's psychotic symptoms, that treatment would give Algere a better chance of overcoming barriers to improving his mental condition. For these reasons, the Court [\*743] finds by clear and convincing evidence that the government's proposed treatment plan is substantially likely to restore Algere to trial competence.

#### **b. Substantially Unlikely to Have Side Effects that Will Interfere Significantly with Ability to Assist Counsel in Conducting a Trial Defense**

As for side effects from antipsychotic medication that might interfere with Algere's ability to assist counsel in his defense, the evidence indicates that such effects vary widely. n3 (*Id.* at 8). Dr. Zula testified that common side effects from Haldol, the medication the government proposes to administer to Algere involuntarily, may include the following.

n3 Once Algere's mental state is stabilized, the doctors opine that the dosage of any antipsychotic medication can be lowered to the minimum dose required to maintain his mental stability, which will minimize the risk of side effects. (*Id.* at 12). They also point out that Algere's anxiety may be reduced after his legal proceedings are over, which would also allow for a reduction in the dosage. (*Id.*). These considerations regard-

ing what might happen in the future, however, are not relevant to the present purpose of determining whether the medication is currently appropriate for the purpose of restoring Algere's competence to stand trial.

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#### *Sedation Side Effects*

Some amount of sedation is likely to be a side-effect of Haldol, along with all other antipsychotic medications, but Dr. Zula testified that the effects are not that severe and are substantially unlikely to interfere with Algere's function and ability to assist counsel. Dr. Zula also testified that sedation effects are greatest in patients who already present apathy as a symptom of their psychosis. Because Algere has a "full affect" without apathy as a symptom, he is substantially unlikely to experience sedation side-effects that will interfere significantly with his ability to assist counsel in conducting a trial defense. The doctors indicated that they will monitor for sedation side-effects and exercise good clinical practice, including changing medication, if sedation effects appear. (*Id.* at 8).

#### *Abnormal Movement Side Effects*

The next group of possible short-term side effects are abnormal movements. Movement-related side effects may include stiffness and tremor, dystonic reactions, and akathisia. All first-generation antipsychotics, including Haldol, are associated with short-term movement side-effects, while second-generation [\*\*22] antipsychotics are less associated with such effects and generally only at higher doses. (*Id.*). These side effects are generally managed by reducing the dose or, if reducing the dose would render the antipsychotic property of the drug ineffective, another medication is prescribed to control the effects or the antipsychotic medication is changed. (*Id.* at 8-10).

Dr. Zula testified that stiffness, tremor and mask-like facial expression, which occurs in 15 to 50 percent of individuals treated with first-generation antipsychotics, can be minimized easily through dose reduction. (Literature Review at 13). If not, benztropine or diphenhydramine are prescribed to relieve these symptoms. (Forensic Addendum at 10). Acute dystonia, which typically manifests as a muscle spasm in up to 10 percent of patients treated with first-generation antipsychotic medication, is easily and effectively relieved by administering an anticholinergic medication. (Literature Review at 14). Akathisia, an uncomfortable restlessness or tension that may produce objective signs of restlessness, occurs in 20 to 30 percent of individuals treated with first-generation [\*744] antipsychotics and is treated by

reducing the [\*\*23] dose of the antipsychotic, switching medications or prescribing an additional medication. (*Id.* at 13). Tardive dyskinesia, the manifestation of writhing movements of muscles in the fingers, hands, arms, lower extremities, or face and tongue, is a side-effect of long term use of first-generation antipsychotic medications at a rate of approximately five percent per year after one year of use, with 60 to 70 percent of the cases described as mild and three to 10 percent described as severe. (*Id.* at 14; Forensic Addendum at 12). Tardive dyskinesia does not interfere with cognition, but more severe cases might be noticeable in a court proceeding. There is a lower risk for development of the disorder, however, in patients Algere's age. (*Id.* at 16). Dr. Zula also testified that during trial, these kinds of movement side effects could be managed with the administration of another medication and, in her opinion, they are substantially unlikely to interfere significantly with Algere's ability to assist his counsel in conducting a trial defense.

#### *Endocrinological Side Effects*

The final group of potential side effects are endocrinologic side effects. Most first-generation [\*\*24] and some second-generation antipsychotics can cause elevated prolactin levels, which may affect the regulation of other hormones and manifest in 25 to 50 percent of men as erectile dysfunction. (Forensic Addendum at 12). The elevated levels "frequently" return to normal when the medication dose is decreased or when a different medication is prescribed. (*Id.*).

The metabolic syndrome is another recognized side effect of second-generation antipsychotic medications and can cause "elevations in weight, blood pressure, blood sugar and cholesterol." (*Id.* at 12). This side effect is detected through a mandatory metabolic monitoring program at the FMC that includes monitoring weight, blood pressure, and serum lipid and glucose levels and also involves dietary and exercise educational classes. (*Id.* at 13). If the metabolic syndrome occurs, appropriate intervention is prescribed, such as dietary changes, recommended exercise, medications for high blood pressure or cholesterol, or a change in antipsychotic medication. (*Id.*). The doctors point out that these endocrinologic side effects are not the kind of effects that would interfere with Algere's ability to assist counsel in his [\*\*25] defense.

Finally, rare and unpredictable reactions to medication are always possible. (*Id.* at 11). For example, neuroleptic malignant syndrome, cause by blood pressure instability and the breakdown of tissue toxic to kidneys, may be fatal. However, it is rare and can be treated by stopping the administration of antipsychotic medication and taking supportive measures. (*Id.*). Medical allergies are also possible, but Dr. Zula testified that the medica-



tion will first be administered in a small test dose to reduce the severity of any potential reaction.

The Court finds that the doctors have carefully considered the benefits and risks for Mr. Algere's proposed treatment and that the proposed treatment with antipsychotic medication is substantially likely to restore Mr. Algere's competency to stand trial and substantially unlikely to produce side effects that will interfere significantly with his ability to aid in his defense.

### 3. No Less Intrusive Means

The third prong of the *Sell* test requires the Court to conclude that involuntary medication is necessary to further the government's interests by finding "that any alternative, less intrusive treatments are unlikely to [\*\*26] achieve substantially the same results." *Sell*, 539 U.S. at 181. Here, the evidence in the [\*745] record indicates that no less intrusive treatments are likely to achieve substantially the same results. Both doctors testified that the chances are very slim that Algere will become competent to stand trial without taking antipsychotic medication, because their experience indicates that restoration of competency rarely happens without the administration of antipsychotic medication. The doctors noted that Algere has been at the FMC for more than twelve months without significant change in his condition. (*Id.* at 13-14). Dr. Zula testified that alternatives such as cognitive behavioral therapy are unlikely to help Algere because a patient has to be receptive to that kind of therapy for it to be effective, and Algere is unwilling to re-examine his delusions. In addition, the doctors have tried and have been unable to engage Algere in these kinds of therapies. The Court therefore finds that less intrusive means are unlikely to achieve substantially the same results as the administration of antipsychotic medication.

The Court is also required to consider whether the less intrusive [\*\*27] means of ordering Algere to undergo the treatment, on pain of contempt, might achieve the same result. *Sell*, 539 U.S. at 181. 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. *See Gomes*, 387 F.3d at 163 (finding that, because defendant repeatedly refused all chemical treatment and appeared to believe that the judiciary was enlisted in a conspiracy against him, a court order was not likely to achieve the same results as forcible medication); *Morris*, 2005 U.S. Dist. LEXIS 38785, 2005 WL 348306, at \*5 (finding that, as defendant was unable to understand his legal situation, a contempt order would be worthless). The Court will nevertheless order that medical personnel treating Algere re-

quest that Algere voluntarily take antipsychotic medication by oral method before any medication is administered involuntarily. The Court concludes that involuntary medication is necessary to further the government's interest because it finds that less alternative treatments [\*\*28] are unlikely to achieve substantially the same results.

### 4. Medical Appropriateness

The fourth prong of the *Sell* test requires the Court to "conclude that administration of the drugs is medically appropriate, *i.e.*, in the patient's best medical interest in light of his medical condition." 539 U.S. at 181. The government must demonstrate that the particular defendant's individual mental and physical condition have been considered in evaluating the proposed course of treatment and concluding that it is medically appropriate. *Evans*, 404 F.3d at 240-41. To do so, the government must:

spell out why it proposed the particular treatment, . . . provide the estimated time the proposed treatment plan will take to restore the defendant's competence and the criteria it will apply when deciding when to discontinue the treatment, describe the plan's probable benefits and side effect risks for the defendant's particular medical condition, . . . show how it will deal with the plan's probable side effects, and explain why, in its view, the benefits of the treatment plan outweigh the costs of its side effects.

*Evans*, 404 F.3d at 242. [\*\*29]

Most of these criteria have already been addressed, and the Court finds that the proposed treatment in this case is medically appropriate for Algere. Antipsychotic medication is the standard treatment [\*746] for Algere's condition, whether inside or outside of an institution like the FMC. (Forensic Addendum of 6/10/05 at 14). Left unmedicated, Algere is subject to adverse consequences, including increased risk of suicide and increased risk of death from natural causes. (*Id.* at 6). Untreated psychosis may even result in permanent damage to a person's brain function. (*Id.* at 7). The proposed treatment has numerous potential positive effects and is expected to significantly improve Algere's quality of life. The doctors testified that Algere lives in a state of constant fear and anxiety, convinced that others are constantly plotting against him, and they are unable to convince him otherwise. The proposed treatment is likely to relieve Algere of these

fears and thereby reduce his anxiety and stress. It is also expected to improve Algere's insight into his illness, which may result in his acceptance of medication voluntarily. Indeed, the doctors testified that the proposed treatment is [\*\*30] necessary to alleviate Algere's suffering and is his only chance to function as an independent member of society. Further, they are unaware of any medical condition Algere has that would be worsened by the administration of the medication or of any other condition that could explain his psychotic symptoms. (*Id.* at 14-15). Any side-effects will be managed as described, and Algere will be placed on the metabolic monitoring protocol to detect any endocrinologic side-effects that may emerge. (*Id.*).

The evidence indicates that the doctors have considered the benefits and potential side effects and concluded that treatment with antipsychotic medication is appropriate for Algere. The treatment will involve a careful oversight by a psychiatrist, who will prescribe medication at an appropriate dosage and monitor Algere for both therapeutic and side effects of the treatment. Based on the June 10, 2005, report and the testimony of Drs. Pyant and Zula, the Court concludes that the proposed administration of anti-psychotic medication is justified because the government has established by clear and convincing evidence that it is medically appropriate, is substantially unlikely to have side [\*\*31] effects, and, taking account of less intrusive alternatives, is necessary to further the important governmental interest of rendering Algere competent to stand trial for a serious offense.

### III. CONCLUSION

Having considered the *Sell* factors and Algere's current lack of competence to stand trial, the Court continues Algere's commitment pursuant to 18 U.S.C. § 4241(d)(2)(A) and GRANTS the government's motion to

have Algere medicated involuntarily to render him competent to stand trial, under the following conditions. FMC personnel must provide Algere with a copy of this Order and Reasons, explain to him the potential side effects of Abilify, and advise him that Abilify must be taken orally at appropriate intervals. They must also explain the potential side effects of Haldol and advise Algere that Haldol is administered by injection at appropriate intervals if he refuses to take Abilify orally. **All medical personnel treating Algere shall request that Algere voluntarily take medication orally before each and every administration of medication by injection.** If Algere does not agree to take Abilify orally within ten days of the date of this Order, [\*\*32] FMC personnel are authorized to administer Haldol by injection over Algere's objection.

Algere shall be confined at the FMC for four months, or a lesser period if reasonably sufficient to restore him to competency. At the end of four months, or when Algere's competency is restored if that occurs in less than four months, a report shall be filed with the Court detailing the [\*747] results of the treatment. The report must set forth the criteria that are used to determine whether Algere has been restored to competence to stand trial and the result of the application of those criteria to Algere's case. If the doctors conclude that Algere has been restored to competence to stand trial, they must also set forth what side effects Algere has experienced on the medication and how the medication will affect Algere at trial.

New Orleans, Louisiana, this 1st day of July, 2005.

SARAH S. VANCE

UNITED STATES DISTRICT JUDGE

# ADDENDUM E

*United States v. Bradley*

LEXSEE

**UNITED STATES OF AMERICA, Plaintiff-Appellee, v. STEVEN PAUL  
BRADLEY, Defendant-Appellant.**

No. 03-8097

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

*417 F.3d 1107; 2005 U.S. App. LEXIS 15477*

July 28, 2005, Filed

**PRIOR HISTORY:** **[\*\*1]** Appeal from the United States District Court for the District of Wyoming. (D.C. No. 03-CR-102-D).\*

tion n1 to the final order rule of 28 U.S.C. § 1291, we affirm.

\* After examining the briefs and appellate record, this panel has determined unanimously that oral argument would not materially assist the determination of this appeal. See *FED. R. APP. P. 34(a)(2)*; *10th Cir. R. 34.1.9(G)*. The case is therefore ordered submitted without oral argument.

n1 [A] preliminary or interim decision is appealable as a collateral order when it (1) conclusively determines the disputed question, (2) resolves an important issue completely separate from the merits of the action, and (3) is effectively unreviewable on appeal from a final judgment." *Sell*, 539 U.S. at 176 (internal quotation marks and citation omitted). An order to involuntarily medicate falls within the collateral order exception. *Id.*

**COUNSEL:** David A. Kubichek, Assistant United States Attorney, (Matthew H. Mead, United States Attorney, with him on the brief ), Casper, Wyoming, for Plaintiff-Appellee.

Ronald G. Pretty, Cheyenne, Wyoming, for Defendant-Appellant.

**JUDGES:** Before SEYMOUR, LUCERO and O'BRIEN, Circuit Judges.

**OPINION BY:** O'BRIEN

**OPINION:** **[\*1109]** O'BRIEN, Circuit Judge.

Steven Paul Bradley (Bradley) was found incompetent to stand trial. Physicians at a government medical facility, however, concluded Bradley's competency to stand trial could be restored through treatment with antipsychotic drugs. After Bradley's repeated refusal to take such medication, the district court, pursuant to the standards set forth in *Sell v. United States*, 539 U.S. 166, 156 L. Ed. 2d 197, 123 S. Ct. 2174 (2003), **[\*\*2]** ordered Bradley to be involuntarily medicated in order to render him competent to stand trial. Bradley appeals this order. Exercising jurisdiction under the collateral order excep-

**[\*1110] I. Background**

On January 31, 2003, Bradley was charged by criminal complaint with violating 18 U.S.C. § 844(i). n2 The complaint alleged that on the previous day, while riding a motorcycle, Bradley lobbed a hand grenade at a group of salesmen gathered in the **[\*\*3]** parking lot of Cowboy Dodge, a vehicle dealership in Cheyenne, Wyoming, because he was dissatisfied with the purchase of a truck from the dealership. Attached to the grenade was a note which read "I want my \$ 26,000.00." In an interview with law enforcement, Bradley admitted to the incident and also indicated he possessed explosives, explosive devices and a firearm at his home because he believed someone was trying to kill him. Bradley was subsequently indicted for violating 18 U.S.C. § 922(g)(1). n3 Later still, he was charged by criminal complaint with violating 18 U.S.C. § § 1951(a) n4 and 924(c)(1)(B)(ii). n5

n2 "Whoever maliciously . . . attempts to damage or destroy, by means of fire or an explosive, any building . . . used in interstate . . . commerce or in any activity affecting interstate . . .

commerce shall be imprisoned for not less than 5 years and not more than 20 years . . . ." 18 U.S.C. § 844(i).

n3 "It shall be unlawful for any person-- (1) who has been convicted in any court of, [sic] a crime punishable by imprisonment for a term exceeding one year . . . to . . . possess in or affecting commerce, any . . . ammunition . . . ." 18 U.S.C. § 922(g)(1). The penalty includes imprisonment for not more than ten years. 18 U.S.C. § 924(a)(2). Bradley had a prior federal conviction for possession with intent to distribute cocaine.

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n4 "Whoever in any way or degree obstructs, delays, or affects commerce or the movement of any article or commodity in commerce, by . . . extortion or attempts . . . so to do . . . shall be . . . imprisoned not more than twenty years . . . ." 18 U.S.C. § 1951(a).

n5 "Any person who, during and in relation to any crime of violence . . . for which the person may be prosecuted in a court of the United States, uses or carries a firearm [destructive device] . . . shall be sentenced to a term of imprisonment of not less than 30 years." 18 U.S.C. § 924(c)(1)(A), (B)(ii).

On February 5, Bradley moved *inter alia* for a determination of competency to stand trial. On February 19, the court granted the motion. See 18 U.S.C. § 4241(a). It ordered Bradley committed for a psychiatric or psychological examination, with report of the results to be submitted to the court. See 18 U.S.C. § 4241(b). See also 18 U.S.C. § 4247(c) (stating requirements for report). On June 19, [\*\*5] with the report in hand, the court conducted a competency hearing. The report, authored by Dr. Richard L. DeMier, Ph.D., n6 diagnosed Bradley with a psychotic mental illness (paranoid schizophrenia), averred he was not a danger to himself or others within the facility, concluded he lacked competency to proceed to trial, n7 and stated Bradley's prognosis was fair:

[Bradley] has no appreciable insight into the nature or ramifications of [his] disorder, and he may be resistant to treatment. Nevertheless, psychiatric medications are generally able to effectively treat symp-

toms such as those displayed by the defendant. It is possible that an extended period of mental health treatment [\*1111] in an inpatient setting would be sufficient to restore his competency. He might well exhibit a therapeutic response to a regimen of psychiatric medications during such a period of hospitalization. Although a positive treatment response cannot be guaranteed, it is a reasonable expectation that Mr. Bradley could be restored to competency following a period of treatment in a structured setting, which included a regimen of psychiatric medications . . . .

(Appellee App. at 30.) On June 19, the [\*\*6] court, on the basis of the report, found Bradley lacked competency to proceed to trial. It ordered him recommitted for treatment and further evaluation to ascertain the likelihood he would regain competence within the foreseeable future. See 18 U.S.C. § 4241(d).

n6 Dr. DeMier is a clinical psychologist attached to the United States Medical Center for Federal Prisoners in Springfield, Missouri.

n7 "Although Mr. Bradley is able to demonstrate a sound understanding of legal processes in the abstract, his psychotic mental illness prevents him from applying that information to his own case in a rational manner." (Appellee App. at 29.)

Three days before the competency hearing, the Supreme Court decided *Sell*, in which it held:

the Constitution permits the Government involuntarily to administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial, but only if the treatment is medically appropriate, [\*\*7] is substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests.

*Sell*, 539 U.S. at 179. With this in mind, the court ordered that Bradley's further evaluation include an "assessment of the relevant factors" stated in *Sell* for the involuntary administration of antipsychotic medication to assist Bradley's return to competence. n8 (*Id.* at 35.)

n8 The court reserved for itself the legal question whether or not involuntary administration of antipsychotic drugs to Bradley would "further important governmental trial-related interests." *Sell*, 539 U.S. at 179. (Appellee App. at 16.)

Pursuant to the court's instruction, Dr. DeMier conducted his follow-up assessment with the following questions in mind:

1. Would Mr. Bradley benefit from treatment with psychiatric medications?
2. Can Mr. Bradley [\*\*8] be persuaded, in consultation with his clinicians, to voluntarily submit to treatment with psychiatric medications?
3. If Mr. Bradley is unwilling to voluntarily submit to treatment with psychiatric medications, would that treatment nevertheless be considered medically appropriate?
4. Would the administration of psychiatric medications have unfavorable side effects which would be substantially likely to undermine the fairness of any trial which might occur in this case?
5. Is treatment with psychiatric medication likely to return Mr. Bradley to a status in which he can substantially assist his attorney in his defense?

(*Id.* at 37.)

In his report, dated August 22, Dr. DeMier again diagnosed Bradley with a psychotic mental illness (paranoid schizophrenia), averred he was not a danger to himself or others within the facility, and concluded he was incompetent to proceed to trial. He answered the questions posed in the court's order as follows:

1. "The treatment of choice for a psychotic disorder is antipsychotic medication. Indeed, antipsychotic medication is essential to the effective treatment of psychotic disorders. . . . Other forms of treatment, [\*\*9] [\*1112] including education, psychotherapy, and behavioral interventions, do not address the essence of the disorder and are unlikely to be successful."

2. Bradley was unwilling to voluntarily submit to treatment with psychiatric medications.

3. "Because treatment with psychiatric medications is the intervention of choice for Mr. Bradley's condition, it is my opinion, as well as the opinion of the psychiatry staff at this facility, that treatment of his illness with psychiatric medications is medically appropriate."

4. The most common side effects of antipsychotic medications are best characterized as nuisance side effects, as their appearance does not entail the risk of serious harm, but only inconvenience or discomfort . . . . More serious side effects are far less common . . . . The vast majority of patients report no serious side effects, and nuisance side effects can be effectively addressed. Some patients report no side effects whatsoever. Especially with the advent of a newer class of "atypical" antipsychotic medications, the appearance of severe side effects is becoming increasingly rare.

The therapeutic effect [of] antipsychotic medication is to improve thinking. [\*\*10] Individuals with psychotic disorders typically have severe impairment in both the form and content of their thoughts. This may include disorganized thoughts, sensory distortions (such as hallucinations), disturbances of emotion, and impairments in the ability to think in a rational or sequential manner. Treatment of these impairments is likely to enhance, rather than undermine, the fairness of any legal proceeding in which the patient is a participant.

5. It is a reasonable expectation, based on the current scientific knowledge in psychiatry and on experiences with many individuals with similar disorders, that Mr. Bradley could be restored to competency following a period of treatment in a structured setting, which included a regimen of psychiatric medications.

(*Id.* at 41-43.)

On November 3, the court conducted another competency hearing. Dr. DeMier testified that Bradley's condition had not changed since the assessment contained in his August 22 report. "The only additional information that's not in the report again has to do with Mr. Bradley's stance since the report was prepared in that he is becoming more and more insistent that he has no mental illness and has [\*\*11] voiced strong opposition to taking medication." n9 (Appellee App. at 58.) The court again found Bradley incompetent to proceed to trial. It adopted Dr. DeMier's findings, addressed each of the *Sell* factors and ordered Bradley to consult with counsel with an eye to voluntarily submitting to the medication. If he did not voluntarily submit with ten days, the court indicated it would enter an order for involuntary administration of the medication. n10 This it did on November 13, 2003:

[\*1113] ORDERED that Defendant, after further consultation with his attorney and the mental health professionals at the U.S. Medical Center for Federal Prisoners in Springfield, Missouri, shall submit to the administration of medication which the Court finds is medically appropriate and necessary to render Defendant competent to stand trial. If Defendant refuses to comply with the Court's order, he will be found in civil contempt.

(Appellant App. at 107.) n11 Bradley appeals.

n9 Bradley himself testified he would refuse to voluntarily take antipsychotic medications; it was his belief they were not medically indicated.

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n10 The district court stated:

An appropriate order compelling [the] administration of this

drug will issue from this Court within ten days from today.

...

The only order that will issue from this Court today, Mr. Bradley, is that you again consult with your lawyer privately regarding these issues and thereafter voluntarily submit to the administration of these drugs. The Court orders you to do that and in doing so intends to exercise its full civil contempt powers.

(Appellant's App. at 98.)

The minute entry in the court's docket characterizes the November 3, 2003 order as follows: "Court finds defendant will benefit from antipsychotic medication and orders if the defendant will not voluntarily take medication the Court will find him in civil contempt and order the involuntary administration of medication." (Appellee's App. at 104.)

n11 The court's order is no less one for the involuntary administration of antipsychotic medication because its means of enforcement is through the exercise of the contempt power of the court rather than by forcible medication. *See Sell*, 539 U.S. at 181 ("The court must consider less intrusive means for administering the drugs, e.g., a court order to the defendant backed by the contempt power, before considering more intrusive methods."). The hallmark of an order for the involuntary administration of medication is that it breaches the defendant's will. *See id.* at 171 ("The staff sought permission to administer the medication against Sell's will. That effort is the subject of the present proceedings.") (emphasis added). A defendant who is unwilling to voluntarily take medication, which fairly describes Bradley, is no less overcome by a threat to be found in contempt than he or she is by being forcibly medicated.

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## II. Standard of Proof & Standard of Review

The Supreme Court in *Sell* articulated neither a standard of proof for the *Sell* factors nor a standard of appellate review. In deciding these standards, we bear in mind that involuntary administration of antipsychotic medications implicates a constitutional right. "An individual has

a constitutionally protected liberty interest [under the *Due Process Clause*] in avoiding involuntary administration of antipsychotic drugs—an interest that only an essential or overriding state interest might overcome." *Sell*, 539 U.S. at 178-79 (internal quotation marks and citation omitted). The standards we set must weigh this vital constitutional interest in the balance.

To date, only one circuit has decided the standard of proof and the standard for appellate review of the *Sell* factors. The Second Circuit first parsed the *Sell* factors into factual and legal questions. It decided "whether the Government's asserted interest is important is a legal question." *United States v. Gomes*, 387 F.3d 157, 160 (2d Cir. 2004), cert. denied, 160 L. Ed. 2d 1081, 125 S. Ct. 1094 (2005). We agree, [\*\*14] with one qualification. We would expand the parameters of the legal question to include whether involuntary administration of antipsychotic drugs "is necessary significantly to further important governmental trial-related interests." *Sell*, 539 U.S. at 179. In other words, "has the Government, in light of the efficacy, the side effects, the possible alternatives, and the medical appropriateness of a particular course of antipsychotic drug treatment, shown a need for that treatment sufficiently important to overcome the individual's protected interest in refusing it?" *Id.* at [\*1114] 183. n12 The Second Circuit determined the remaining *Sell* factors depend upon factual findings and ought to be proved by the government by clear and convincing evidence. *Gomes*, 387 F.3d at 160. Recognizing the vital constitutional liberty interest at stake, we agree. We review conclusions of law *de novo* and findings of fact for clear error. *Stillwater Nat'l Bank & Trust Co. v. CIT Group/Equipment Finan. Inc.*, 383 F.3d 1148, 1150 (10th Cir. 2004).

n12 See also *United States v. Sell*, 282 F.3d 560, 568 (8th Cir. 2002) (citation omitted), vacated by 539 U.S. 166, 156 L. Ed. 2d 197, 123 S. Ct. 2174 (2003).

The first question, therefore, is whether the district court erred by holding that the government's interest in bringing *Sell* to trial is sufficient to outweigh *Sell*'s interest in refusing medication. This is a mixed question of law and fact, so we review the district court's finding *de novo*. To make this determination, we must weigh the government's interest in rendering *Sell* competent against *Sell*'s inter-

est in refusing unwanted medication.

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### III. Discussion

The question whether a district court has followed the correct procedures under *Sell* for involuntary administration of antipsychotic medication to a non-dangerous criminal defendant for the purpose of rendering him competent to stand trial n13 is one of first impression in this circuit. We first observe the predicate for the *Sell* factors is clearly established by the record. There is no dispute Bradley is mentally ill. Nor is it contested he faces serious criminal charges (the three pending criminal charges against him permit imprisonment for a total of 50 years). We now take up the propriety of the court's order with respect to the *Sell* factors *ad seriatim*.

n13 In *Sell*, the Supreme Court stated that it was not necessary for a court to satisfy the standards for involuntary administration of antipsychotic drugs in order to render a defendant competent to stand trial if there was an independent and sufficient basis to otherwise order their administration, such as where the defendant is dangerous or where withholding of the drugs would endanger his or her health. *Sell*, 539 U.S. at 181-83. The record in this case provides no basis for an order for involuntary administration of antipsychotic drugs on the basis of dangerousness or threat to health.

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We turn first to the factual findings. *Sell* directs the court to determine whether or not administration of antipsychotic medication is medically appropriate, "i.e., in the patient's best medical interest in light of his medical condition. The specific kinds of drugs at issue may matter here as elsewhere. Different kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success." *Sell*, 539 U.S. at 181. This necessarily includes a determination that administration of the drug regimen is "substantially likely to render the defendant competent to stand trial." *Id.*

Dr. DeMier characterized administration of antipsychotic medication in general as "the treatment of choice for a psychotic disorder" and superior to non-pharmaceutical interventions. (Appellee App. at 41.) He indicated that while some patients may suffer side effects from administration of antipsychotic medications, these are typically of the nuisance variety and able to be effec-



tively treated. He added that "use of the newer 'atypical' antipsychotic medications has largely eliminated the necessity to prescribe a second medication to alleviate side effects. [\*\*17] " (*Id.* at 42.) Also, with the newer drugs, "severe side effects [are] becoming increasingly rare." (*Id.*) He cautioned that "because individuals vary greatly in their therapeutic responses to psychiatric medications, and in their susceptibility to side effects, it is important [\*1115] to continue to monitor them regularly." (*Id.* at 43.) Most significant, in our view, was Dr. DeMier's observation that "individuals with psychotic disorders typically have severe impairment in both the form and content of their thoughts[.]" and "the therapeutic effect [of] antipsychotic medication is to improve thinking." (*Id.*) In his opinion,

[a] course of inpatient mental health treatment which includes the administration of psychiatric medications is usually sufficient to restore a defendant to competency. It is the experience of the clinicians at this facility that more than 80% of defendants committed for competency restoration treatment are later deemed competent by the trier of fact.

(*Id.*) He was guardedly optimistic that administration of antipsychotic medication would materially aid in restoring Bradley to competency. Based on Dr. DeMier's report and testimony, [\*\*18] the district court found that Bradley would

substantially benefit from the administration of psychiatric medications . . . and that the therapeutic effect of these antipsychotic medications far outweigh any potential negative side effects to their administration and that, in any event, there are appropriate mechanisms available to monitor the defendant's administration of these drugs to ensure that he does not suffer from some adverse consequence of these drugs.

(*Id.* at 83-84.)

The excerpted record admits of little challenge to the proposition that administration of antipsychotic drugs would substantially aid Bradley's return to competency. We conclude the Government met its burden of establishing by clear and convincing evidence that such a

regimen was medically appropriate, and the district court did not clearly err in so finding.

Next, *Sell* directs an inquiry into whether "administration of the drugs is substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense, thereby rendering the trial unfair." *Id.* Dr. DeMier initially reported that while Bradley had [\*\*19] a "sound understanding of legal processes in the abstract, his psychotic mental illness prevents him from applying that information to his own case in a rational manner." (Appellee App. at 29.) He later added that "treatment of [his] impairments [with antipsychotic drugs] is likely to enhance, rather than undermine, the fairness of any legal proceeding in which the patient is a participant." (*Id.* at 43.) The court so found. The record is bereft of any challenge to this proposition. It is patent from the evidence. Therefore, the court did not clearly err in its finding.

Finally, "the court must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results. And the court must consider less intrusive means for administering the drugs, *e.g.*, a court order to the defendant backed by the contempt power, before considering more intrusive methods." *Id.* at 181 (citations omitted). As earlier noted, Dr. DeMier reported that an antipsychotic drug regimen was the treatment of choice for psychosis and far superior to non-pharmaceutical interventions. There is nothing in the record to rebut this proposition. To the end, the court tried [\*\*20] to induce Bradley to voluntarily consent to the drug therapy. Even as it entered its order for involuntary administration of antipsychotic drugs, the court ordered Dr. DeMier and Bradley's counsel to separately confer with Bradley on the advantage of voluntarily submitting to treatment.

[\*1116] Furthermore, the court considered and ordered a less intrusive means of implementing its order for involuntary drug therapy. If Bradley continued to refuse to take the drugs, the consequence was not that he would be forcibly medicated against his will, but that he would have to answer to the court for his refusal. This is a measured and appropriate response by the district judge to the circumstances presented. Therefore, we conclude the Government met its burden in establishing by clear and convincing evidence that less intrusive treatments were "unlikely to achieve substantially the same results," *id.*, as drug therapy, and the court did not err in so finding.

We now turn to the court's legal conclusions. *Sell* first requires a legal determination whether "important governmental [trial-related] interests are at stake." *Id.* at 180. The district court concluded in the affirmative. [\*\*21] *Sell* elaborates on this requirement. It does so in

the context of well-settled law that considers the Government's interest in bringing a criminal defendant to trial to be fundamental. *See Illinois v. Allen*, 397 U.S. 337, 347, 25 L. Ed. 2d 353, 90 S. Ct. 1057 (1970) (Brennan, J., concurring) (The "constitutional power to bring an accused to trial is fundamental to a scheme of 'ordered liberty' and prerequisite to social justice and peace."). However, while "the Government's interest in bringing to trial an individual accused of a serious crime is important . . . courts must consider the facts of the individual case in evaluating the Government's interest in prosecution. Special circumstances may lessen the importance of that interest." *Sell*, 539 U.S. at 180.

The Court offered two examples of special circumstances. In the first, a defendant, in the absence of court-ordered administration of psychiatric medication, might suffer lengthy civil commitment for mental illness "that would diminish the risks that ordinarily attach to freeing without punishment one who has committed a serious crime." *Id.* In the second, a defendant may have already been confined [\*\*22] for a lengthy period of time pending a determination of competency, confinement for which he or she would receive credit against any sentence ultimately imposed. *Id.* As we read *Sell*, this latter example suggests that when the amount of time the defendant is confined pending determination of competency is in parity with an expected sentence in the criminal proceeding, the Government may no longer be able to claim an important interest in prosecution.

Neither example applies here. The federal civil commitment statute requires a showing that the proposed patient presents "a substantial risk of bodily injury to another person or serious damage to property of another[.]" 18 U.S.C. § 4246(a). The State of Wyoming, where Bradley is domiciled, requires proof of mental illness for civil commitment, WYO. STAT. ANN. § 25-10-110(j), with mental illness defined as "a physical, emotional, mental or behavioral disorder which causes a person to be dangerous to himself or others and which requires treatment[.]" WYO. STAT. ANN. § 25-10-101(a)(ix). Dr. DeMier reported Bradley presented no threat to himself [\*\*23] or others within the facility where he was held. n14 He testified he did not evaluate for risk to persons or property outside of the facility. In all, the record does not support [\*\*117] the proposition that Bradley would be a candidate for civil commitment. n15

n14 "His behavior has been cordial, cooperative, and he's exhibited no behaviors at this facility that have caused us any concern for our safety or the safety of other people around Mr. Bradley within this setting." (Appellee App. at 57.)

n15 We hasten to add, as the District of Columbia Circuit has noted, that while civil commitment might reduce the danger to the community posed by an individual,

the civil commitment argument assumes that the government's essential penological interests lie only in incapacitating dangerous offenders. It ignores the retributive, deterrent, communicative, and investigative functions of the criminal justice system, which serve to ensure that offenders receive their just deserts, to make clear that offenses entail consequences, and to discover what happened through the public mechanism of trial.

*United States v. Weston*, 347 U.S. App. D.C. 145, 255 F.3d 873, 882 (D.C. Cir. 2001).

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Nor does the second example apply. Less than nine months elapsed between Bradley's commitment for competency examination and the court's order for involuntary administration of antipsychotic drugs. This span of time pales in comparison to the fifty years imprisonment Bradley faces if convicted of the charges against him. Without an order for the involuntary administration of antipsychotic drugs, and with Bradley's continuing refusal to voluntarily accept such drug therapy, the additional length of time Bradley could be held pending competency determination is limited. *See* 18 U.S.C. § 4241(d).

Apart from these failed examples, we can identify no other special circumstances tending to diminish the importance of the Government's interest in restoring Bradley to competence so that he may face trial. Therefore, we find no error in the court's legal conclusion that important Government interests are at stake in restoring Bradley to competency.

Finally, we reach the ultimate legal question whether involuntary administration of antipsychotic drugs "is necessary significantly to further," *Sell*, 539 U.S. at 179, the important governmental trial-related [\*\*25] interests in returning Bradley to competency. Here, the court's factual findings come into play. Without any one of these findings, it is impossible to say that involuntary admini-

stration of antipsychotic drugs would further the Government's interest in restoring Bradley to competency. *See id. at 181*. However, with the court having not clearly erred in making any of its findings, we easily conclude its order for involuntary administration of antipsychotic drugs will significantly further important governmental trial-related interests. In other words, the need for treatment with antipsychotic drugs is "suffi-

ciently important to overcome [Bradley's] protected interest in refusing it." *Id. at 183*.

#### ***IV. Conclusion***

Accordingly, we **AFFIRM** the order of the district court.