

SELL V. UNITED STATES: THE APPROPRIATE STANDARD FOR INVOLUNTARILY ADMINISTERING ANTIPSYCHOTIC DRUGS TO DANGEROUS DETAINEES FOR TRIAL

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INTRODUCTION

In *Sell v. United States*,¹ the United States Supreme Court held that the Constitution allows the government to administer antipsychotic drugs involuntarily to a mentally ill criminal detainee in order to render that defendant competent to stand trial for serious, but nonviolent crimes.² Drawing closely from the standards articulated in the earlier cases of *Washington v. Harper*³ and *Riggins v. Nevada*,⁴ the six-justice majority in *Sell* drew a four-part test⁵ for determining when the government may constitutionally involuntarily administer antipsychotic drugs to detainees for trial competency purposes when they are on trial for *non-violent* crimes, and have not been dangerous in the prison context.⁶ Specifically, the Court held:

[T]he 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 [(1)] treatment is medically appropriate, [(2)] is substantially unlikely to have side effects that may undermine the fairness of the trial, and, [(3)] less intrusive treatments are unlikely to achieve substantially the same results, and the treatment is [(4)] necessary . . . to further important governmental trial-related interests.⁷

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¹ 539 U.S. 166 (2003).

² *Id.* at 169.

³ 494 U.S. 210 (1990).

⁴ 504 U.S. 127 (1992).

⁵ 539 U.S. at 179.

⁶ *Id.* at 169.

⁷ *Id.* at 180-81.

In doing so, however, the Court suggested that lower courts should first consider whether involuntary medication is permissible on the ground that the detainee is dangerous.⁸ Alternatively, if the detainee is not dangerous, as a last resort, the Court maintains that the government could still involuntarily medicate these pre-trial detainees under the *Sell* standard.⁹ This Comment argues that this suggestion is problematic, for it leaves dangerous pre-trial detainees with little of the Sixth Amendment protections¹⁰ that the *Sell* four-part test provides non-violent detainees.

What the *Sell* Court overlooked is that the *Harper* standard, which applies to violent inmates, was created for *post-conviction* prison inmates, where Sixth Amendment fair trial protections are not implicated. By contrast, individuals like the detainees in *Sell* and *Riggins* are *pre-trial* detainees, which means that Sixth Amendment trial protections should apply. The *Sell* standard properly takes Sixth Amendment concerns into account, whereas *Harper* does not. The *Sell* Court, therefore, was wrong to instruct governments to attempt to involuntarily medicate *pre-trial* detainees under *Harper* because their Sixth Amendment rights will be ignored, and pre-trial detainees will be left to suffer antipsychotic drugs' side effects that may alter the detainee's demeanor and personality in ways that can prejudice facets of his defense.¹¹

Part I of this comment discusses the pre-existing standards in this area of law prior to *Sell*, focusing on the "dangerousness" test of *Washington v. Harper* and the trial competence test highlighted in *Riggins v. Nevada*. Part II analyzes the Supreme Court's decision in *Sell v. United States*, paying special attention to the nuances between the different courts' decisions throughout the case's procedural history.

Among other things, Part III provides a discussion of the Sixth Amendment issues implicated in this situation, focusing primarily on the right to a fair trial, competency, courtroom appearance and

⁸ *Id.* at 182-83.

⁹ 539 U.S. at 182-83.

¹⁰ The Sixth Amendment provides:

In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the State and district wherein the crime shall have been committed, which district shall have been previously ascertained by law, and to be informed of the nature and cause of the accusation; to be confronted with the witnesses against him; to have compulsory process for obtaining witnesses in his favor, and to have the Assistance of Counsel for his defence.

U.S. CONST. amend. VI.

¹¹ *Riggins*, 504 U.S. at 142-43 (Kennedy, J., concurring).

demeanor, and their effects on jury deliberations. This section lays the groundwork for how the side effects of these antipsychotic drugs implicate Sixth Amendment concerns. Further, Part III broadly discusses different regimens of antipsychotic drugs similar to those being implemented to patients suffering illnesses comparable to Charles Sell, their impact on the body, their curative tendencies, and the brutal side effects that oftentimes result.

Lastly, Part III discusses the problem with *Sell*. Although the *Sell* four-part test properly addresses the side effects of antipsychotic drugs and their oftentimes prejudicial impact on detainees' Sixth Amendment concerns, the Court's accompanying instructions on the test's application are flawed. The *Sell* Court should have limited *Harper's* application to dangerous, post-conviction inmates *only* and should have instructed courts to apply the *Sell* standard to *all* pre-trial detainees. Only then can all pre-trial detainees be guaranteed to have their Sixth Amendment trial rights weighed against the oftentimes devastating side effects of the drugs the government is attempting to forcefully administer to them. To instruct otherwise, as the *Sell* Court has done, deprives individuals of their constitutional rights in favor of achieving an unfair conviction.

I. PRE-EXISTING PRECEDENT FOR *SELL*:

WASHINGTON V. HARPER AND *RIGGINS V. NEVADA*

In *Sell*, the Supreme Court seemingly combined the rationale utilized in the *Harper*¹² and *Riggins*¹³ decisions for determining when the government can involuntarily administer antipsychotic drugs to detainees, who are not dangerous in the prison environment, for trial competency purposes for non-violent crimes.¹⁴ A brief analysis of those two cases follows.

A. *Washington v. Harper*

In 1976, Walter Harper was sentenced to prison for robbery.¹⁵ Harper was mentally ill and, while incarcerated, was administered antipsychotic drugs like Mellaril.¹⁶ He was granted parole in 1980, conditioned upon his participation in psychiatric treatment.¹⁷

¹² 494 U.S. at 210.

¹³ 504 U.S. at 127.

¹⁴ *Sell*, 538 U.S. at 177-79 ("Two prior precedents, *Harper* . . . and *Riggins* . . . set forth the framework for determining the legal answer.").

¹⁵ *Harper*, 494 U.S. at 213.

¹⁶ *Id.* at 213-14 n.1.

¹⁷ *Id.*

Through 1981, he continued to receive psychiatric treatment until he assaulted two hospital nurses, and his parole was revoked.¹⁸ In 1982, after voluntarily receiving antipsychotic drugs for many years, Harper refused to continue taking the prescribed medications.¹⁹ Thereafter, according to procedure, the treating physician sought to medicate Harper over his objections.²⁰ Harper filed suit claiming the institution's policy to involuntarily administer the medication violated the Due Process, Equal Protection, and Free Speech Clauses of both the Federal and State constitutions.²¹ After seven years of hearings and appeals, the United States Supreme Court granted certiorari.²²

In *Harper*, the Court held that even though individuals have a "significant" constitutionally protected "liberty interest" in "avoiding the unwanted administration of antipsychotic drugs,"²³ where the inmate is "dangerous" and based on the nature of the prison environment,²⁴ states have a legitimate and important interest in forced medication.²⁵

Further, the Court stated, the Due Process Clause allows a prison inmate suffering from serious mental illness to be involuntary treated with antipsychotic drugs, "[1] if the inmate is dangerous to himself or others and [(2)] the treatment is in the inmate's medical interest."²⁶ The *Harper* Court's reasoning, which first recognized a constitutionally protected interest in the right to refuse medical treatment,²⁷ revolved around such factors as Harper already being convicted and him being dangerous to inmates and staff because of a mental illness.²⁸

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Harper*, 494 U.S. at 217.

²² *Id.* at 218.

²³ *Id.* at 221. In *Harper*, the Supreme Court recognized for the first time that there is a constitutionally protected interest in the right to refuse medical treatment. *Id.* at 221-22.

²⁴ *Id.* at 227.

²⁵ *Id.* at 225.

²⁶ *Harper*, 494 U.S. at 227.

²⁷ *Id.* at 221-22.

²⁸ See Dennis E. Cichon, *The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 LA. L. REV. 283, 417 (1992). *Harper* claimed the extent of a prisoner's right to refuse "must be defined in the context of the inmate's confinement." *Harper*, 494 U.S. at 222.

B. *Riggins v. Nevada*

Unlike in *Harper*, where the convicted inmate was dangerous in the prison context, in *Riggins*, the defendant was a pre-trial detainee.²⁹ Riggins was awaiting trial for a violent crime—he had allegedly stabbed his victim repeatedly to death³⁰—and since Riggins suffered from mental illness, the government requested he be treated with Mellaril for trial competency purposes.³¹ The State, relying on Nevada Revised Statute § 178.400 (1989), which allowed involuntary administration of antipsychotic drugs for trial competence purposes, put Riggins on trial.³² Riggins then moved to terminate the administration of the drugs, arguing the drugs “denied him the ability to assist in his own defense and prejudicially affected his attitude, appearance, and demeanor at trial,” and without the medication, Riggins would be incompetent, and therefore could not stand trial.³³ In a one-page decision, giving no indication of the court’s rationale, the trial court denied the motion and subsequently, the State administered the drugs, Riggins was convicted, and sentenced to death.³⁴

In *Riggins*, the Court granted certiorari to decide whether involuntary administration of antipsychotic drugs during a detainee’s trial violated the Sixth and Fourteenth Amendments.³⁵ Although the Court overturned Riggins’ conviction because the “district court allowed administration of Mellaril to continue without making . . . any findings,”³⁶ the Court stated it would have allowed the involuntary administration provided certain standards were followed.³⁷ The Court stated that the “Fourteenth Amendment affords at least as much protection to persons the State detains for trial,”³⁸ and although there exist no standards for judging involuntary administration of antipsychotic drugs in trial and pre-trial situations, the State “*would* have satisfied due process if the prosecution had demonstrated . . . that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives,

²⁹ *Riggins*, 504 U.S. at 135.

³⁰ *Id.* at 129.

³¹ *Id.* at 129-30.

³² *Id.* at 130.

³³ *Id.* at 131.

³⁴ *Id.* at 129-31. Subsequently, the Nevada Supreme Court affirmed Riggins’ conviction and death sentence. *Riggins*, 504 U.S. at 132.

³⁵ *Id.* at 132-33.

³⁶ *Id.* at 136 (emphasis in original).

³⁷ *Id.* at 135.

³⁸ *Riggins*, 504 U.S. at 135.

essential for the sake of Riggins' *own safety or the safety of others*.”³⁹ Similarly, the Court added, the State “might have been able to justify . . . involuntary [drug] treatment . . . by establishing that it could not obtain an adjudication of Riggins' guilt or innocence” of the murder charge “by using less intrusive means.”⁴⁰

II. *SELL V. UNITED STATES*

In *Sell*, the factual background presented a novel situation to the Supreme Court—unlike Walter Harper, Charles Sell was not dangerous in the prison context so a *Harper* analysis alone was insufficient. Similarly, unlike David Riggins, Charles Sell was awaiting trial for non-violent crimes so he did not fit neatly under the Court's *Riggins* standard. Thus, the Supreme Court needed to articulate a new standard to address the concerns Charles Sell's case presented—a non-dangerous pre-trial detainee on trial for a non-violent crime.

A. *Sell: Factual Summary and Procedural History*

Sell, once a practicing dentist, had a long and unfortunate history of mental illness and in 1982, “after telling doctors that the gold he used for fillings had been contaminated by communists,” was hospitalized for psychotic tendencies, treated, and subsequently discharged.⁴¹ In 1984, Sell was hospitalized and again released after calling and requesting the police to shoot a leopard that was attempting to board a bus outside his office.⁴² Sell's activity turned criminal in 1997 when he was charged with submitting fictitious insurance claims for payment, and shortly thereafter Sell and his wife were charged with “56 counts of mail fraud, 6 counts of Medicaid fraud, and 1 count of money laundering.”⁴³ Then, at one point in 1998, Sell was charged with the attempted murder of his arresting FBI

³⁹ *Id.* (emphasis added).

⁴⁰ *Id.* Professor Cichon wrote in response to *Riggins*:

Although the majority refused to mandate substantive criteria in *Riggins*, it did suggest a more rigorous standard of review for the involuntary medication of pretrial detainees than that articulated in *Harper* for convicted inmates. Rather than deferring to a rational state interest as in *Harper*, the Court indicated that “safety considerations or other compelling concerns” must be asserted in order to override a pretrial detainee's liberty interest in refusing antipsychotic drugs.

Cichon, *supra* note 28, at 418-19.

⁴¹ *Sell*, 539 U.S. at 169-70 (quoting App. at 146).

⁴² *Id.* (citing App. at 148).

⁴³ *Id.* (citing App. at 12-22). At this time, Sell was held competent to stand trial by a federal magistrate judge, and was released on bail. *Id.* (quoting App. at 321).

agent as well as a former co-worker who was planning to testify against Sell in the fraud case.⁴⁴

In 1999, after being found incompetent to stand trial by the magistrate, Sell moved for reconsideration and was ordered to be sent to the United States Medical Center for Federal Prisoners for up to four months to receive hospitalized treatment.⁴⁵ During this time, the medical center staff recommended that Sell take antipsychotic medication, and soon sought to administer the drugs against his will.⁴⁶ In August 2000, by court order, the magistrate authorized the involuntary administration of antipsychotic drugs to Sell but stayed the order allowing Sell to appeal the issue to the district court.⁴⁷ In April 2001, although not affirming the decision based on the magistrate's findings, the district court found the magistrate's "dangerousness" determination clearly erroneous, and affirmed the use of the drugs for trial competency purposes.⁴⁸

Sell and the Government both appealed the district court's decision, and in March 2002, the Eighth Circuit Court of Appeals affirmed.⁴⁹ A divided panel affirmed the district court, holding that Sell was not dangerous,⁵⁰ but declared that administering the drugs involuntarily to ensure Sell's competence to stand trial was lawful because the "government has an essential interest in bringing a defendant to trial," and there were no less intrusive means to do so.⁵¹ Moreover, a majority of the Eighth Circuit found antipsychotic drug treatment "medically appropriate" for Sell and that with the drugs, there was a reasonable probability that Sell could participate in his trial.⁵²

⁴⁴ *Id.* (citing App. at 23-29). The attempted murder charge was joined with the fraud charges for trial. *Id.*

⁴⁵ *Sell*, 539 U.S. at 170 (citing App. at 323).

⁴⁶ *Id.* at 172 (citing App. at 323).

⁴⁷ *Id.* at 173 (quoting App. at 333-34). The magistrate found that Sell was such a danger to himself and others in the institution, that medication would be the only way to render him less dangerous, so the new drugs will ameliorate side effects, the drugs' benefits outweigh the risks, and the drugs have a substantial probability of returning Sell to competency. *Id.*

⁴⁸ *Id.* at 173-74 (quoting App. at 349, 349 n.5, 354).

⁴⁹ *Sell*, 539 U.S. at 173-74 (citing *United States v. Sell*, 282 F.3d 560 (8th Cir. 2002)).

⁵⁰ *Sell*, 282 F.3d at 565 (referring to an incident Sell had with a nurse at the medical center, the Eighth Circuit held his behavior at the medical center, at the most, amounted to an "inappropriate familiarity and even infatuation' with a nurse").

⁵¹ *Id.* at 568.

⁵² *Sell*, 539 U.S. at 174-75 (citing *Sell*, 282 F.3d at 571-72).

The United States Supreme Court “granted certiorari to determine whether the Eighth Circuit ‘erred in rejecting’ Sell’s argument that ‘allowing the government to administer antipsychotic medication against his will solely to render him competent to stand trial for non-violent offenses,’ . . . improperly depriv[ed] Sell of an important ‘liberty’ that the Constitution guarantees.”⁵³ The six-justice majority held that the Constitution authorizes the government to administer antipsychotic drugs involuntarily to a mentally ill criminal detainee in order to render that defendant competent to stand trial for serious, but non-violent crimes.⁵⁴ Justice Breyer, writing for the majority, drew from *Harper* and *Riggins* a four-part test for determining those instances in which the government can involuntarily administer antipsychotic drugs to detainees for trial competency purposes when they are not dangerous in the prison context.⁵⁵ The Court stated:

[T]he 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 [(1)] *treatment is medically appropriate*, [(2)] *is substantially unlikely to have side effects that may undermine the fairness of the trial*, and, [(3)] *less intrusive treatments are unlikely to achieve substantially the same results*, and the treatment is [(4)] *necessary . . . to further important governmental trial-related interests*.⁵⁶

Justice Breyer cautioned, however, that situations where the government could utilize the standard “solely for trial competence purposes . . . may be rare.”⁵⁷

The first element requires a court to find “that *important* governmental interests are at stake.”⁵⁸ Under this prong, the Court recognized the existence of an important governmental interest in bringing an individual, whether being accused of a serious crime against the person or property, to trial.⁵⁹ The Court declared that lower courts must engage in case-by-case factual determinations in evaluating the government’s interest because certain circumstances

⁵³ *Id.* at 175 (quoting Petitioner’s Brief at I, *Sell* (No. 02-5664); U.S. CONST. amend. V) (citations omitted).

⁵⁴ *Sell*, 539 U.S. at 169.

⁵⁵ *Id.* at 178-79.

⁵⁶ *Id.* at 179-80 (emphasis added).

⁵⁷ *Id.* at 180.

⁵⁸ *Id.* (emphasis in original).

⁵⁹ *Id.* (citing *Riggins*, 504 U.S. at 135-36) (“In both instances the Government seeks to protect through application of the criminal law the basic human need for security.”).

may lessen the importance of the interest in bringing the detainee to trial.⁶⁰ For example, the interest in bringing the defendant to trial might be lessened in situations where civil commitment is an alternative option to incarceration without a criminal trial.⁶¹ Justice Breyer warned the “potential for future confinement affects, but does not totally undermine, the strength of the need for prosecution.”⁶² The Court, however, warned, the “Government has a concomitant, constitutionally essential interest in assuring that the defendant’s trial is a fair one.”⁶³

During step two of the analysis, the “court must conclude that involuntary medication will *significantly further* those concomitant state interests,” of prong one.⁶⁴ Here, the court is required to determine that the antipsychotic “drugs . . . [are] substantially likely to render the defendant competent to stand trial” as well as find that the medication(s) are “*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.”⁶⁵ In this step, the majority cited Justice Kennedy’s concurrence in *Riggins*, voicing the Sixth Amendment concerns of presentation in the courtroom—like in-court demeanor, behavior, manner, facial expressions, emotional responses, and their impression on the jury.⁶⁶ Moreover, Justice Kennedy discussed how antipsychotic drugs prejudice the defendant by rendering him unable, and sometimes too lethargic, to assist counsel in his defense.⁶⁷

Step three requires the court to “conclude that involuntary medication is *necessary* to further those [state] interests.”⁶⁸ In other words, the court must conclude “that any alternative, less intrusive treatments are *unlikely to achieve substantially* the same results . . . ,”

⁶⁰ *Sell*, 539 U.S. at 180.

⁶¹ *Id.* (“The defendant’s failure to take drugs voluntarily . . . may mean lengthy confinement in an institution for the mentally ill . . . [that] would diminish the risks that ordinarily attach to freeing without punishment one who has committed a serious crime. We do not mean to suggest that civil commitment is a substitute for a criminal trial. The Government has a substantial interest in timely prosecution.”).

⁶² *Id.* (“The same is true of the possibility that the defendant has already been confined for a significant amount of time (for which he would receive credit toward any sentence ultimately imposed, see 18 U.S.C. § 3585(b)).”).

⁶³ *Id.* at 181.

⁶⁴ *Id.* (emphasis added).

⁶⁵ *Id.* (citing *Riggins*, 504 U.S. at 142-45 (Kennedy, J., concurring)) (emphasis added).

⁶⁶ *Sell*, 539 U.S. at 181 (citing *Riggins*, 504 U.S. at 142-45 (Kennedy, J., concurring)).

⁶⁷ *Id.*

⁶⁸ *Id.*

including, “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.”⁶⁹

Last, in step four, the “court must conclude that administration of the drugs is *medically appropriate*” for the detainees’ situation.⁷⁰ The Court noted that antipsychotic drugs may have differing success rates and may cause different side effects, so within this prong, the medication must be “in the patient’s best medical interest in light of his medical condition,”⁷¹ and also, the “specific kinds of drugs at issue may matter here as elsewhere.”⁷²

In terms of application, the Court noted that the *Sell* four-part test only deals with the competency to stand trial and suggested that courts need not consider these factors when the individual’s dangerousness is the issue, like in *Harper*.⁷³ The Court stated that employing *Sell* protections should be used as a last resort, claiming, “[t]here are often strong reasons for a court to determine whether forced administration of drugs can be justified on these alternative grounds *before* turning to the [*Sell*] question,”⁷⁴ and moreover, Justice Breyer stated, the dangerousness test is usually more “objective and manageable . . . [and] a court . . . should ordinarily determine whether the Government [seeks or has first sought] permission for forced administration of drugs on these other *Harper*-type grounds; and, if not, why not.”⁷⁵ Further, he stated, the “need to consider

⁶⁹ *Id.* (emphasis added). In this prong, the majority cites the Amicus Curiae Brief for the American Psychological Association that states, “nondrug therapies may be effective in restoring psychotic defendants to competence.” *Id.* The Court also cites the Amicus Curiae Brief for the American Psychiatric Association that states, “alternative treatments for psychosis commonly not as effective as medication,” which contrasts the American Psychological Association brief. *Id.*

⁷⁰ *Sell*, 539 U.S. at 181 (emphasis in original).

⁷¹ *Id.*

⁷² *Id.* at 181.

⁷³ *Id.* at 181-82.

⁷⁴ *Id.* (emphasis in original).

⁷⁵ *Sell*, 539 U.S. at 182-83 (quoting *Riggins*, 504 U.S. at 140). Under the less protective *Harper* standard, the state can medicate a detainee against his will if 1) the inmate displays an amount of “dangerousness” to himself or others and, 2) the treatment is within the medical interest of the inmate. *Harper*, 494 U.S. at 227. *Sell* offers substantially more protection to the detainees, requiring the court to find that 1) important governmental interests are at stake, 2) the medication will significantly further those interests, 3) involuntary medication is necessary to further those interests, and 4) the administration of the drugs must be medically appropriate for the patient. *Sell*, 539 U.S. at 180-81 (citing *Riggins*, 504 U.S. at 140 (Kennedy, J., concurring)). The *Sell* court cited Justice Kennedy’s *Riggins* concurrence incorrectly in this context. Kennedy did not suggest that alternative means to involuntarily administer the drugs should be employed first before a *Sell*-like inquiry. In *Riggins*,

authorization on trial competence grounds will likely disappear” if the Court were to authorize the medication on “alternative grounds,”⁷⁶ and the “medical experts may find it easier to provide an informed opinion about whether, given the risk of side effects, particular drugs are medically appropriate and necessary to control a patient’s potentially dangerous behavior . . . than to try to balance harms and benefits related to the more quintessentially legal questions of trial fairness and competence.”⁷⁷

B. Standard Applied to Charles Sell: The Decision

Sell’s administrative Medical Center hearing and the federal magistrate’s hearing approved the involuntary administration of antipsychotic drugs to Sell on the *Harper* “dangerousness” grounds alone.⁷⁸ In contrast, the district court and the Eighth Circuit found the court’s application of the “dangerousness” standard clearly erroneous, adopting a *Riggins* rationale, and agreed that the drugs could be administered solely to render Sell competent enough to stand trial even though he was not dangerous to himself or others.⁷⁹ Although the Supreme Court voiced its discomfort with the Eighth Circuit’s conclusion that Sell was not “dangerous,” the Supreme Court assumed the Eighth Circuit’s decision was correct because the Government did not contest the matter on appeal.⁸⁰

he simply made reference to the distinction between the two sets of inquiries and how they both fit certain circumstances. *Riggins*, 504 U.S. at 140 (Kennedy, J., concurring) (“This is not a case like [*Harper*], in which the purpose of the involuntary medication was to ensure that the incarcerated person ceased to be a physical danger to himself or others. The inquiry in that context is both objective and manageable. Here, [in *Riggins*] the purpose of the medication is not merely to treat a person with grave psychiatric disorders and enable that person to function and behave in a way not dangerous to himself or others, but rather to render the person competent to stand trial.”).

⁷⁶ *Sell*, 539 U.S. at 183.

⁷⁷ *Id.* at 182. Even further in this vein, according to the majority, the Court would prefer to remove this whole inquiry away from the criminal realm and into the civil realm when possible. Justice Breyer suggests that the *Harper* inquiry is equated with “medical treatment as a civil matter” and every state provides avenues through which the involuntary administration of medication can be authorized, and if a court were to authorize “medication on these alternative grounds, the need to consider authorization on trial competence grounds will likely disappear.” *Id.* at 182-83 (citing 28 CFR § 549.43 (2002); ALA. CODE §§ 26-2A-102(a), 26-2A-105, 26-2A-108 (Michie 1992); ALASKA STAT. §§ 13.26.105(a), 13.26.116(b) (2002); ARIZ. REV. STAT. ANN. §§ 14-5303, 14-5312 (West 1995); ARK. CODE ANN. §§ 28-65-205, 28-65-301 (1987)).

⁷⁸ *Sell*, 539 U.S. at 183.

⁷⁹ *Id.* at 184.

⁸⁰ *Id.* at 184 (“If anything, the record before us, described in Part I, suggests the contrary.”).

The Supreme Court held that although it could have approved the antipsychotic drugs for trial competency purposes if it met the new *Sell* standard, the Eighth Circuit incorrectly approved the administration of drugs to Sell because the government failed to meet that standard.⁸¹ The Court was concerned with the lack of breadth of the discussion at the federal magistrate's hearing, which focused mostly on Sell's "dangerousness," and left unmentioned most of the factors articulated in the new four-part test.⁸² Moreover, the Supreme Court noted as problematic the hearing record's absence of meaningful discussion about the drugs' side effects, the drugs' adverse effects on communication with counsel, the drugs' chances of sedating the defendant, and the drugs' impact on quelling detainees' expressive emotions after courtroom trial developments, stating these concerns tend to undermine the fairness of trial and are all considerations under the new *Sell* standard.⁸³ Additionally, the Court questioned why the lower court did not address the fact that Sell would not be a threat to the community because he had already been confined at the Medical Center and will continue to be held there if he does not take the medication.⁸⁴ For these reasons, the majority vacated and remanded the Eighth Circuit's judgment so the government could pursue forced medication on either the *Sell* articulated factors, the *Harper* dangerousness grounds, or both.⁸⁵

⁸¹ *Id.* at 185.

⁸² *Id.* at 185.

⁸³ *Id.* (citing *Riggins*, 504 U.S. at 142-45 (Kennedy, J., concurring)).

⁸⁴ *Sell*, 539 U.S. at 186.

⁸⁵ *Id.* Justice Scalia, joined by Justices Thomas and O'Connor dissented, primarily disagreeing with the majority's finding that the issue on appeal falls within the collateral order doctrine. *Id.* at 186-87 (Scalia, J., dissenting). Justice Scalia did not believe there was a final judgment, and because of this, the Court of Appeals should not have heard the appeal. *Id.* The dissent claimed Sell's pretrial order did not fit neatly under the collateral order doctrine test because the issue failed element three which is: "(3) effectively unreviewable on appeal from a final judgment." *Id.* at 189 (Scalia, J., dissenting) (quoting *Coopers & Lybrand*, 437 U.S. at 468). Justice Scalia determined that Sell's "order is reviewable on appeal from conviction and sentence," and therefore the petitioner will have to wait until after the final judgment to appeal a "postdeprivation vacatur of conviction" as opposed to a "predeprivation injunction." *Sell*, 539 U.S. at 189-90 (Scalia, J., dissenting). Calling it a "breathtaking expansion of appellate jurisdiction over collateral orders," Justice Scalia warned that the majority's decision seemingly will allow criminal defendants to engage in opportunistic behavior by allowing them to refuse their medication halfway through their trial, and demanding "an interlocutory appeal from the order that medication continue on a compulsory basis." *Id.* at 191 (Scalia, J., dissenting). Further, Justice Scalia believed the correct procedural avenue Sell should have taken would have been to obtain a "pre-trial review of the . . . medication order by filing suit under the Administrative Procedure Act, 5 U.S.C. § 551 *et. seq.*," or by filing a *Bivens* "action, which is available to federal pretrial detainees challenging the

III. *SELL* ESSENTIALLY INSTRUCTS LOWER COURTS TO IGNORE
DETAINEES' SIXTH AMENDMENT RIGHTS.

A. *Competence, the Constitution, and Involuntary Medication to
Render Competence*

It is a common thread of American jurisprudence that the conviction of an incompetent defendant violates due process.⁸⁶ Incompetency, or insufficient mental capacity, has been defined as whether or not the defendant could rationally consult with counsel and whether or not he rationally and factually understands the proceedings.⁸⁷ A competency determination alone is not sufficient to guard against an unfair trial, but competency is necessary "because the elements of a fair trial presuppose, and depend upon, mental competence."⁸⁸ Obviously, the government has a constitutional requirement to render criminal detainees competent to stand trial and the involuntary administration of antipsychotic drugs to detainees for that purpose raises many Sixth Amendment concerns.⁸⁹

Generally, the Sixth Amendment ensures that defendants in criminal prosecutions "be informed of the nature and cause of the accusation; to be confronted with the witnesses against him; to have compulsory process for obtaining witnesses in his favor, and to have the Assistance of Counsel for his defence."⁹⁰ The Supreme Court has

conditions of their confinement . . ." *Id.* at 193 (Scalia, J., dissenting) (citing *Bivens v. Six Unknown Fed. Narcotics Agents*, 403 U.S. 388 (1971)).

⁸⁶ See Vickie L. Feeman, Note, *Reassessing Forced Medication of Criminal Defendants in Light of Riggins v. Nevada*, 35 B.C. L. REV. 681, 704 (1994) (citing *Dusky v. United States*, 362 U.S. 402, 402 (1960)).

⁸⁷ *Id.*

⁸⁸ William P. Ziegelmueller, *Supreme Court Review: Sixth Amendment-Due Process on Drugs: The Implications of Forcibly Medicating Pretrial Detainees With Antipsychotic Drugs: Riggins v. Nevada*, 112 S. Ct. 1810 (1992), 83 J. CRIM. L. & CRIMINOLOGY 836, 846 (1993).

⁸⁹ See *Riggins*, 504 U.S. at 142 (Kennedy, J., concurring) ("The side effects of antipsychotic drugs may alter demeanor in a way that will prejudice all facets of the defense. Serious due process concerns are implicated when the State manipulates the evidence in this way.").

⁹⁰ U.S. CONST. amend. VI; see also M. Catherine Healy, Comment, *Riggins v. Nevada: Are "Synthetically Sane" Criminal Defendants Competent to Stand Trial?*, 20 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 385, 407 (1994). These Sixth Amendment rights have been incorporated to state courts through the Due Process Clause of the Fourteenth Amendment thus further providing, "the fundamental elements of fairness in a criminal trial." U.S. CONST. amend. XIV; see also Healy, *supra* note 90, at 408 (quoting *Faretta v. California*, 422 U.S. 806, 818 (1975) (announcing "because these rights are basic to our adversary system of criminal justice, they are part of the 'due process of law' [sic] that is guaranteed by the Fourteenth Amendment to defendants in the criminal courts of the States"))).

held that one “accused of a crime is entitled to have his guilt or innocence determined solely on the basis of the evidence introduced at trial, and not on grounds of official suspicion, indictment, continued custody, or other circumstances not adduced as proof at trial.”⁹¹ Along this rationale, the Court held that a defendant may be prejudiced if he appears before a jury bound and gagged.⁹² Similarly, in *Estelle v. Williams*,⁹³ the Court held that a state cannot require defendants to be tried while wearing prison uniforms.⁹⁴

The drugs’ effect on a detainee’s in-court demeanor is a major concern; a defendant on drugs, who appears in a trance-like state or is suffering from spastic body movements like lip smacking and involuntary pelvic movements⁹⁵ will likely have a prejudicial effect on the jury. Commentators maintain that frequent use of the antipsychotic drug Mellaril makes defendants “stoned for all practical purposes and [they] can barely function.”⁹⁶

Along these lines, the Supreme Court has held that if a defendant cannot actively cooperate with his lawyer, the defendant’s right to effective assistance of counsel has been compromised.⁹⁷ A defendant has the right to provide advice to his counsel about his defense and it is within his rights “to supercede his lawyer altogether and conduct the trial himself.”⁹⁸ Naturally, in order for the defendant to make decisions about these rights, and assist in his defense, he must be competent and not under the influence of

⁹¹ *Taylor v. Kentucky*, 436 U.S. 478, 485 (1978).

⁹² *Illinois v. Allen*, 397 U.S. 337, 344 (1970) (“Not only is it possible that the sight of shackles and gags might have a significant effect on the jury’s feelings about the defendant, but the use of this technique is itself something of [an] affront to the very dignity and decorum of judicial proceedings that the judge is seeking to uphold.”). In certain extreme situations though, the Court noted, “binding and gagging might possibly be the fairest and most reasonable way to handle” a disruptive defendant. *Id.*

⁹³ 425 U.S. 501 (1976).

⁹⁴ *Id.* at 504-05 (stating no “essential state policy” was served by compelling the defendant’s dress, the Court said, “[t]he actual impact of a particular practice on the judgment of jurors cannot always be fully determined,” so courts “must do the best they can to evaluate the likely effects of a particular procedure, based on reason, principle, and common human experience”).

⁹⁵ See *infra* note 115 and accompanying text.

⁹⁶ See Elizabeth A. Schmidlein, Note, *Riggins v. Nevada: The Accused’s Right to “Just Say No” to Antipsychotic Drugs?*, 10 J. CONTEMP. HEALTH L. & POL’Y 541, 544 (1994) (quoting *Riggins*, 504 U.S. at 1819 (Kennedy, J., concurring) (quoting doctor who examined Riggins at his competency hearing)).

⁹⁷ *Massiah v. United States*, 377 U.S. 201 (1964); *Geders v. United States*, 425 U.S. 80 (1976).

⁹⁸ See Ziegelmüller, *supra* note 88, at 846 (citing *Faretta v. California*, 422 U.S. 806, 816 (1975) (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 106 (1934))).

debilitating drugs so he can understand the nature of the proceedings that surround him.⁹⁹

Clearly these Sixth Amendment concerns are implicated when defendants are under the influence of antipsychotic drugs. When patients undergo antipsychotic treatment, their personalities change dramatically—overwrought patients become lethargic, emotional outbursts cease as the “synthetically sane” patient enters a zombie-like trance.¹⁰⁰ Commentators state that this “exercise of ‘duress on [a] witness’ mind [so] as to preclude him from making a free and voluntary choice’ regarding his testimony is an infringement on a defendant’s right to a fair trial.”¹⁰¹

B. *Effects of Antipsychotic Drugs*

It is important to discuss different antipsychotic drugs and the problematic tendencies that oftentimes result from their administration. Psychotropic drugs, including antipsychotics, tranquilizers, sedatives, and hypnotics, affect the mental processes by altering an individual’s brain chemical balance, which hopefully affects the cognitive process in a remedial way.¹⁰² Although the medical world does not fully understand how the drugs combat psychosis, it is believed that the drugs manipulate dopamine levels produced in the brain.¹⁰³ There is no agreement on what mental conditions are best treated by drugs,¹⁰⁴ but it is agreed that the drugs only suppress, and do not cure mental illness, and that they provide no curative effect once they leave the blood stream.¹⁰⁵

Antipsychotics’ “effectiveness varies from condition to condition, symptom to symptom and patient to patient,” and because of this, psychiatrists face difficulty prescribing medications due to the inability to predict the drugs’ effect on a particular patient.¹⁰⁶ A medication regimen, therefore, is usually prescribed based on custom within the profession, rather than through calculated analysis.¹⁰⁷

⁹⁹ See *Drope v. Missouri*, 420 U.S. 162, 171-73 (1975).

¹⁰⁰ See Feeman, *supra* note 86, at 699.

¹⁰¹ See Ziegelmüller, *supra* note 88, at 846-47 (citing U.S. CONST. amend. VI); *Webb v. Texas*, 409 U.S. 95, 98 (1972).

¹⁰² See William M. Brooks, *Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs*, 31 IND. L. REV. 937, 945 (1998).

¹⁰³ *Id.*

¹⁰⁴ See Feeman, *supra* note 86, at 698.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* (citing Robert Plotkin, *Limiting the Therapeutic Orgy: Mental Patients’ Right to Refuse Treatment*, 72 NW. U. L. REV. 461, 461 (1977); Lawrence D. Gaughan & Lewis

Moreover, the patient's appropriate dosage is a product of guesswork and trial and error with the administered amount increased until either there is a curative effect or toxic symptoms develop.¹⁰⁸ Even then, any curative effect may be temporary because individuals' drug responses vary over time,¹⁰⁹ and when side effects present themselves, they sometimes persist for years after the medication is stopped.¹¹⁰

Some common side effects of antipsychotic drugs are pronounced sedation, a condition occurring after the drugs chemically dull patients' thought processes and flatten their emotional responses.¹¹¹ Personalities change dramatically as a result of the medications; overwrought patients become lethargic, and emotional outbursts cease as the "synthetically sane" patient enters a zombie-like trance.¹¹² This "chemical lobotomy," a term coined by opponents of the drugs, forces patients to feel drowsy, disoriented, and unable to stay awake.¹¹³ Generally, the side effects can be characterized into two groups: extrapyramidal and non-neurological symptoms.¹¹⁴

Within the extrapyramidal symptoms category, most of the disorders are extremely harmful, involving the medications' effect on the brain's extrapyramidal system, which is the part of the body's involuntary nervous system that directs coordination of muscular movements.¹¹⁵ This classification contains five main disorders: tardive dyskinesia, parkinsonism, akathisia, dystonic reactions, and neuroleptic malignant syndrome.¹¹⁶

H. La Rue, *The Right of a Mental Patient to Refuse Antipsychotic Drugs in an Institution*, 4 LAW & PSYCHOL. REV. 43, 47 (1978)).

¹⁰⁸ See Feeman, *supra* note 86, at 698.

¹⁰⁹ *Id.* at 699.

¹¹⁰ *Id.* at 700.

¹¹¹ *Id.* at 699.

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ See Cichon, *supra* note 28, at 297-301; see also Brooks, *supra* note 102, at 947-51. Not all the side effects fit neatly into these two categories. For example, there are many other minor side effects of antipsychotic drugs like blurred vision, dry mouth, and minor interference with sexual functioning. *Id.* at 950. Additionally, constipation, urinary retention, and eye and severe skin disorders, including major discoloration, have been noted. See Schmidlein, *supra* note 96, at 545. Certain behavioral impairments have been noted to occur such as toxic confusion, insomnia, schizophrenic symptoms, and bizarre dreams. *Id.* It is easy to see how many of these behaviors and grotesque movements are embarrassing for the patient and the family to endure. See Feeman, *supra* note 86, at 700.

¹¹⁵ See Cichon, *supra* note 28, at 300.

¹¹⁶ *Id.*

Tardive dyskinesia, the most damaging disorder, is an unpredictable, irreversible disorder that involves spastic body movements, ranging from lip smacking and involuntary pelvic movements, to difficulty in breathing, talking, and swallowing.¹¹⁷ Parkinsonism's victims resemble someone afflicted with Parkinson's disease, showing a "mask-like face, drooling, muscle stiffness and rigidity."¹¹⁸ Akinesia, which is a subcategory of parkinsonism, is a socially debilitating side effect whose victims seem lethargic to the point that any intellectual interests, like communication and reading, become impossible.¹¹⁹ Akathisia, a disorder exhibiting symptoms including painful irritability, pacing, fidgeting, and the constant tapping of the feet is problematic in that patients reach such a point of extreme panic that it oftentimes displays symptoms worse than the underlying illness.¹²⁰ Dystonic reactions, characterized by muscular

¹¹⁷ See Brooks, *supra* note 102, at 948-49; see also Feeman, *supra* note 86, at 700. Antipsychotic drugs oftentimes mask the symptoms of tardive dyskinesia—these symptoms may not expose themselves until the regimen is decreased or discontinued which is why doctors fail to diagnose this disorder almost ninety percent of the time. See Brooks, *supra* note 102, at 949 (quoting Kenneth A. Kessler & Jeremy Waletzky, *Clinical Use of Antipsychotic*, 138 AM. J. PSYCHIATRY 202, 205 (1981)). Studies indicate the prevalence of tardive dyskinesia approximately range from ten to fifty percent; the federal judiciary is also in disagreement but the Supreme Court in *Harper* has indicated the incidence of the disorder at ten to twenty-five percent while district courts, for example, *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), have held the number as high as fifty-six percent. See Brooks, *supra* note 102, at 949-50 (citing *Rogers*, 478 F. Supp. 1342; *Harper*, 494 U.S. 210).

¹¹⁸ See Brooks, *supra* note 102, at 948 (quoting Plotkin, *supra* note 107, at 475). Prevalence rates of parkinsonism are difficult to determine—studies have indicated that five to ninety percent of patients suffer from the disorder. *Id.*

¹¹⁹ See Brooks, *supra* note 102, at 948; see also Cichon, *supra* note 28, at 301. Doctors note difficulty in diagnosing this disorder, mostly because the patient's peaceful, apathetic state masks discomfort to the point where they will actually deny difficulties. Around thirty-five percent on certain medications develop akinesia and anti-parkinsonian drugs assist, but usually will never offer curative effects to the disorder. See Cichon, *supra* note 28, at 301.

¹²⁰ See Cichon, *supra* note 28, at 301-02. Akathisia, which has been linked to suicidal and homicidal behavior, is difficult to diagnose and the prevalence of the side effect is staggering. *Id.*; see also Brooks, *supra* note 102, at 947-48 (stating that "[p]sychiatrists often fail to diagnose akathisia as it may be impossible to distinguish between akathisia and psychotic excitement. Because psychiatrists often misinterpret symptoms of akathisia as a worsening of a patient's psychiatric condition, physicians will react by increasing the dosage level of medication."). Further,

[o]ne early study found that forty-five percent of the patients observed experienced akathisia at one time or another. A more recent study, however, indicates a much higher prevalence rate. After only one five milligram dose of haloperidol, sixty-four percent of the test group experienced akathisia, with twenty-two percent suffering a severe case. At the end of one week of treatment with a daily ten milligram dose, seventy-six percent of the patients experienced the impairment. Sixty-

spasms in the eyes, face, neck, and arms are severe short-term side effects, and most likely, these horrible symptoms would be present during the detainee's trial.¹²¹ The last side effect within the extrapyramidal class is neuroleptic malignant syndrome, which produces symptoms ranging from elevated blood pressure, delirium, mutism, and in some cases, to coma.¹²²

The second group of characterized side effects is the non-neurological disorders, which mostly involve sexual dysfunctions, blood, endocrine, and hormonal disorders.¹²³ In males, sexual dysfunctions have ranged from impotence, inability to ejaculate, or to the more severe reversal of ejaculation into the bladder.¹²⁴ Also, induced priapism can result, which is a sustained erection that occurs without stimulation.¹²⁵ The erection, which is extremely painful, does not subside, oftentimes requiring emergency surgery.¹²⁶ Endocrine and hormonal disorders have also been reported as non-neurological side effects, some including an increased appetite that leads to substantial weight gain.¹²⁷ Females have been reported to experience irregularities in the menstrual cycle, sometimes resulting in infertility, as well as spontaneous lactation, and in males, breast enlargement can occur.¹²⁸ In addition, skin disorders develop ranging from rashes to irreversible pigment discoloration.¹²⁹

Certain blood disorders, most notably dyscrasias, which are disorders resulting from toxic and/or allergic effects of certain drugs on the hematologic system, also fall within the non-neurological category.¹³⁰ Agranulocytosis, a life-threatening decrease in infection-destroying white blood cells, is the most serious blood dyscrasia and is

three percent of another test group experienced akathisia after four weeks of treatment with a fixed dose of thiothixene.

Cichon, *supra* note 28, at 302.

¹²¹ See Brooks, *supra* note 102, at 948.

¹²² *Id.* at 950. Although approximately two percent of patients who use neuroleptic medication exhibit symptoms of this disorder out of the thousands suffering from it, death will result twenty to thirty percent of the time. *Id.* at 951; see also Cichon, *supra* note 28, at 309-10.

¹²³ See Cichon, *supra* note 28, at 298.

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ *Id.*; see Schmidlein, *supra* note 96, at 545.

¹²⁸ See Cichon, *supra* note 28, at 298; see also Schmidlein, *supra* note 96, at 545.

¹²⁹ See Cichon, *supra* note 28, at 298.

¹³⁰ *Id.*

characterized by sore throat, fatigue, fever, jaundice, eye lesions, and skin discoloration.¹³¹

Clearly, the ‘brutality of these side effects is apparent and it is no wonder why commentators maintain “‘even acutely disturbed patients might have good reason to refuse these drugs.’”¹³²

C. *Sell Instructs the Government to Apply Harper before Sell and This is Unconstitutional Because it Ignores Detainees’ Sixth Amendment Rights in Favor of a Less Onerous Standard*

The *Sell* four-part test properly addresses Sixth Amendment concerns incident to the involuntarily administration of antipsychotic drugs to pre-trial detainees. The Court makes reference to these concerns, first mentioned in Justice Kennedy’s *Riggins* concurrence, in the second prong of the *Sell* four-part test by stating lower courts “must conclude that involuntary medication will *significantly further* those concomitant state interests,” but also it “must find that 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.”¹³³

Specifically, in *Riggins*, Justice Kennedy devoted eight pages to a discussion of his skepticism that the state will ever be able to demonstrate enough justification to allow involuntary medication to detainees to render them competent for trial.¹³⁴ His skepticism is rooted in the drugs’ brutal side effects and their effects on detainees’ Sixth Amendment rights such as the “right to effective assistance of counsel, the rights to summon, to confront, and to cross-examine witnesses, and the right to testify on one’s own behalf or to remain silent without penalty for doing so.”¹³⁵

Even though the *Sell* Court should have discussed further, and perhaps even expanded on Justice Kennedy’s concerns, this Comment will assume the Court fully accepted Justice Kennedy’s

¹³¹ *Id.*; see Brooks, *supra* note 102, at 950.

¹³² See Brooks, *supra* note 102, at 951 (quoting *Rennie v. Klein*, 476 F. Supp. 1294, 1299 (D.N.J. 1979)).

¹³³ *Sell*, 539 U.S. at 181 (citing *Riggins*, 504 U.S. at 142-45 (Kennedy, J., concurring)) (emphasis in original).

¹³⁴ *Riggins*, 504 U.S. at 138-39 (Kennedy, J., concurring) (“[A]bsent an extraordinary showing by the State, the Due Process Clause prohibits prosecuting officials from administering involuntary doses of antipsychotic medicines for purposes of rendering the accused competent for trial . . .”).

¹³⁵ *Id.* at 139-40 (Kennedy, J., concurring) (citing *Drope v. Missouri*, 420 U.S. 162, 171-72 (1975)).

Riggins concurrence in prong two of the *Sell* standard.¹³⁶ This endorsement, although cursory, evidences the fact that the Court recognized these Sixth Amendment concerns and the brutal side effects of the drugs. What is problematic with *Sell*, however, is the Court's accompanying suggestion that it should first consider whether involuntary administration of drugs is permissible under *Harper* for a dangerous detainee.

The *Sell* Court's instruction urging lower courts to apply *Harper* before the *Sell* standard is problematic because it ignores vital Sixth Amendment concerns. A commentator was quick to question whether the fact that Harper was in prison *after* a conviction was a factor the Court took into account in the *Harper* analysis.¹³⁷ In *Sell*, however, there is no mention of criminal conviction being a prerequisite to forcefully administering antipsychotics to detainees under the *Harper* "dangerousness" grounds.¹³⁸ What was overlooked with this instruction is that the *Harper* standard was created for situations involving *post-conviction* prison inmates.¹³⁹ Obviously, in those situations, Sixth Amendment fair trial protections are not implicated anymore. In contrast, individuals like the subjects in *Sell* and *Riggins* are *pre-trial* detainees, so Sixth Amendment trial protections *still* apply, being implicated once post formal initiation of the adversarial process began.

In *Riggins*, Justice Kennedy spoke out about these constitutional issues, focusing primarily on the drugs' inherent risks.¹⁴⁰ The

¹³⁶ See *Sell*, 539 U.S. at 181 (citing *Riggins*, 504 U.S. at 142-45 (Kennedy, J., concurring)).

¹³⁷ See generally Cichon *supra* note 28, at 288-89.

¹³⁸ The record at the federal magistrate's hearing focused primarily on *Sell*'s "dangerousness" and the Court was concerned with the sparse discussion about the factors articulated in the new four-part test. *Id.* at 185. Moreover, the Supreme Court noted problematic the hearing record's absence of meaningful discussion about the drugs' side effects, the drugs' adverse effects on communication with counsel, the drugs' chances of sedating the defendant, and the drugs' impact on quelling detainees' expressive emotions after courtroom trial developments, stating these concerns tend to undermine the fairness of trial, all of which are considerations under the new *Sell* standard. *Id.* at 185 (citing *Riggins*, 504 U.S. 127 at 142-45 (Kennedy, J., concurring)). Additionally, the Court questioned why the lower court did not address the fact that *Sell* would not be a threat to the community because he had already been confined at the Medical Center and will continue to be held there if he does not take the medication. *Sell*, 539 U.S. at 186. For these reasons, the majority vacated and remanded the Eight Circuit's judgment so the government could pursue forced medication on either the *Sell* articulated factors, the *Harper* dangerousness grounds, or both. *Id.*

¹³⁹ *Harper*, 494 U.S. at 221-22.

¹⁴⁰ See Ziegelmueller, *supra* note 88, at 855 (citing *Riggins*, 504 U.S. at 1818 (Kennedy, J., concurring)).

defendant's demeanor, both on the witness stand and at counsel table, is affected due to the drugs' side effects, which implicate Sixth Amendment Confrontation Clause arguments.¹⁴¹ Further, the side effects potentially prejudice the accused by interfering with the attorney-client relationship.¹⁴² Justice Kennedy believed that the state has an interest in synthetically altering the detainee's competence level, but if "the defendant cannot be tried without his demeanor being affected in this substantial way by involuntary treatment, in [his] view the Constitution requires that society bear this cost" of civil commitment.¹⁴³ The *Sell* standard adopts these views. But clearly, the Court's accompanying instruction bypassing these concerns in favor of a less onerous standard is anathema to detainees' Sixth Amendment rights. The *Sell* Court seemingly overlooked this important aspect and, therefore, was wrong to instruct governments to attempt to involuntarily medicate *any* pre-trial detainee, dangerous or not, under *Harper* at all.

The *Sell* Court should have limited *Harper's* application to dangerous, *post-conviction* detainees and should have required *Sell* to be applied to all *pre-trial* detainees. Only then can all pre-trial detainees be guaranteed to have their Sixth Amendment trial rights weighed against the oftentimes devastating side effects of the drugs the government is attempting to forcefully administer to them before they are put on trial for frequently serious charges, even some punishable by death. To instruct otherwise, as the *Sell* Court has done, favors deprivation of mentally ill individuals' constitutional rights in favor of achieving an unconstitutional result—an unfair trial, unfair conviction, and inevitably, an unfair sentence.

CONCLUSION

The involuntary administration of antipsychotic medication to render detainees competent to stand trial is an extremely controversial and troubling issue.¹⁴⁴ For many years, courts have

¹⁴¹ *Id.* at 855-56 (citing *Riggins*, 504 U.S. at 1818 (Kennedy, J., concurring)). This is even more important in a capital case where the defendant's demeanor will affect the jury's character assessment in determining whether the defendant lives or dies. *Id.*

¹⁴² *Id.* at 856 (citing *Riggins*, 504 U.S. at 1820 (Kennedy, J., concurring)).

¹⁴³ *Id.* (quoting *Riggins*, 504 U.S. at 1820 (Kennedy, J., concurring) (Justice Kennedy would allow forced medication "only when the State can show that involuntary treatment does not cause alterations [in demeanor] . . .").

¹⁴⁴ See Aaron M. Nance, Comment, *Balking at Buying What the Eight Circuit is Selling: United States v. Sell and the Involuntary Medication of Incompetent, Non-Dangerous, Pretrial Detainees Cloaked with the Presumption of Innocence*, 71 UMKC L. REV. 685, 715 (2003).

struggled and failed to formulate tests that strike the appropriate balance between protecting individuals' rights while respecting the State's interest in prosecuting defendants.¹⁴⁵ In *Sell*, the Court granted certiorari intending to clear up years of confusion within the forced medication realm, but in reality, failed because the Court instructs governments to attempt to involuntarily medicate *any* pre-trial detainee, dangerous or not, under *Harper* first, before applying *Sell*. This instruction favors depriving mentally ill individuals' Sixth Amendment rights in favor of achieving an unconstitutional result—an unfair trial, unfair conviction, and inevitably, an unfair sentence. The *Sell* Court should have limited *Harper*'s application to dangerous, post-conviction detainees, and should have required *Sell* to be applied to all pre-trial detainees—only then can the detainees' Sixth Amendment rights be properly accounted for.

¹⁴⁵ *Id.* at 716. Prior to *Sell*, then-student (later Professor) Aaron Nance wrote: Ultimately, the issue of “forced injection” appears to be as novel, and unsettled, as it was a decade ago when the Supreme Court handed down the enigma of *Riggins v. Nevada*. The Court will have to take a “forced injection” case at some point, which may be sooner rather than later, and only then will we know whether sacrificing a defendant’s individual rights in the name of criminal justice is worth the price of all the new, and possibly more difficult, legal questions that practice naturally generates.

Id.