Forced Medication and Competency to Stand Trial: Clinical, Legal, and Ethical Issues

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The authors examine legal and ethical challenges for the psychiatrist when a defendant who is incompetent to stand trial declines to take prescribed psychotropic medication.

This article discusses, in part:
- Competency evaluations and restoration efforts for defendants
- Circumstances in which prescribed medication may be administered involuntarily
- Legal and scientific sources of authority
- Ethical and practical sources of authority
- Nonmedical interventions
- Recommendations for practice

Psychotropic medications are often crucial in restoring criminal defendants to competency to stand trial. However, some defendants committed for competency evaluations or restoration refuse medications. Thus, psychiatric professionals who work in jails and secure hospitals, and even in community mental health settings, may encounter questions about involuntarily medicating patients who are incompetent for trial.

Legal sources of authority
Competency to stand trial is one of several competency issues within the criminal law. A series of cases decided by the US Supreme Court provides guidance on several circumstances in which a patient incompetent for trial may be involuntarily medicated (local jurisdictions may have slightly different—typically stricter—requirements than the available US Supreme Court precedent).

There are 2 particular circumstances in which prescribed medication may be administered involuntarily; both assume that voluntary administration has been declined. The first is when the patient is dangerous to himself or others. The second, described in Sell v United States,[1] concerns a patient (such as the federal defendant at issue in Sell) who refuses medications in the face of serious charges, but is neither dangerous nor incompetent to make treatment decisions. The Supreme Court held that involuntary medication for such a patient (ie, solely for restoration) is only allowable when:

1) The medication is substantially likely to restore competence.

2) The medication is substantially unlikely to have adverse effects that will significantly infringe on the defendant’s trial rights (eg, demeanor relevant to one’s ability to testify and not prejudice the fact finder against him or her in the presentation of an effective defense; cognitive functioning as relevant to following the proceedings and consulting with counsel). Sell v United States[1] concerns a patient (such as the federal defendant at issue in Sell) who refuses medications in the face of serious charges, but is neither dangerous nor incompetent to make treatment decisions.

3) Less intrusive alternatives are substantially unlikely to achieve restoration.

4) Important prosecutorial interests are at stake (eg, seriousness of the alleged offense, blameworthiness considering the defendant's prior criminal record, and need for confinement to protect public safety); in both scenarios, the medication must also be in the patient’s medical interest.

Also important is the fact that restoration efforts may not continue indefinitely. The decision in Jackson v Indiana[2] concerned a patient with a poor prognosis for restoration whose indefinite commitment for improbable restoration was successfully challenged as inconsistent with constitutional equal protection and due process guarantees. The Court held that once it has been determined within a “reasonable period of time” that a patient is not substantially likely to be restored in the “foreseeable future,” the patient must be must be civilly committed, if appropriate, or released.
Legal, clinical, and ethical rationales that have been advanced for a right to refuse unwanted medications include:

- Liberty as a matter of due process
- Bodily integrity as a matter of a right to privacy
- That the informed consent doctrine should apply to all persons as a matter of due process
- Free speech
- The prohibition on cruel and unusual punishment
- Respect for personhood and autonomy
- Decreasing the number and dosage of medications prescribed
- Decreased prescribing delegations to non-physicians
- Increased procedural justice
- The need for data to substantiate concerns about threats to the refusing patient’s well-being or disruption to the treatment milieu (eg, safety, other patients’ care) absent involuntary treatment

Contrasting concerns include that:

- Without treatment, individuals may well experience distressing and neurotoxic symptoms, more frequent seclusion, and longer periods of hospitalization than might otherwise be necessary
- Perceptions by staff of increased burden, lower quality of treatment, and increased danger
- The financial and productivity costs of review procedures

Judicial opinions have historically reflected a particular concern about the adverse effects of typical antipsychotics. Although the use of atypical antipsychotics addresses some of these concerns, these medications still present their own adverse effects and administration challenges. The question of who grants the involuntary petition is also controversial. The debate has included calls for more neutral judicial decision-making via adversarial procedures versus the desire for increased efficiency and decreased costs. Medication refusal and forced medication are associated with longer hospitalization.

Other issues include the standard used for surrogate decision-making, the level of dangerousness that may be required, and the degree of scrutiny of specific medications with respect to medical appropriateness. Other concerns question what “substantially likely” means, specific trial rights that could be compromised by side effects, the effectiveness of less intrusive interventions, the treatment setting (inpatient or outpatient), and local procedures. These issues often vary by jurisdiction and hence require a review of statutory, administrative, and case law as well as international human rights laws.

**Scientific sources of authority**

Medications are the most common restoration intervention. However, less than one-tenth of the available restoration studies have involved a medication-only approach—combined medical and nonmedical interventions are the norm. Moreover, some patients decline medications, as do other forensic and civil patients, especially those with schizophrenia and anosognosia. The use of ECT for restoration is rare.

Nonmedical interventions (ie, psycholegal education, cognitive remediation, special programs for those with neurodevelopmental disorders, individual psychological treatment) are commonly utilized and evaluated. No randomized direct comparisons of psychotropic medications versus nonmedical interventions for restoration have been conducted because of ethical constraints. However, detailed administrative data and sophisticated data analyses can tease apart the unique and incremental effectiveness of different restoration treatment components.

Nevertheless, standard practice, practical realities (eg, patients who lack insight and refuse to participate in non-medical interventions), and research on treatment for psychosis in general—which indicates the importance of medications in patients’ care notwithstanding the potential positive effects of adjunctive non-medical interventions—suggest that patient responsiveness to medications is the strongest predictor of restoration.

To date, outcome evaluations of multimodality restoration services have not been very specific about the details of the individual treatment elements. Restoration services are often slower and less effective with patients who have intellectual disability and other severe cognitive impairments, although medications for comorbid mental disorders in this population may assist restoration. Also relevant is research on coercion in civil commitment, positive (eg, persuasion, reward-based inducements) versus negative (eg, threats, force) pressures, and procedural justice strategies (essentially attentive, open, and respectful collaboration and negotiation between the patient and all others involved in his or her care) to reduce perceived coercion. Issues often vary by jurisdiction and hence require a review of statutory, administrative, and case law as well as international human
Depending on the study, estimates of the frequency of refusals among patients who are incompetent to stand trial have ranged from relatively rare to more frequent. Certain distinguishing characteristics of patients who decline medication are more likely to be clinical variables (e.g., a schizophrenia diagnosis, a co-occurring substance use disorder, a history of psychiatric hospitalizations) than demographic or criminal justice factors. The reasons asserted by patients for refusing medication are often irrational or disorganized (e.g., illness denial, delusions about medication, reasons unclear).

Medication refusal and forced medication are associated with longer hospitalization. Findings are mixed as to whether medication refusal relates to an increased probability of non-restoration. Also, among patients incompetent to stand trial, younger age was related to longer treatment duration, and as treatment duration increased, the odds of restoration decreased. Petitions for involuntary medication patients are often granted whether the review procedure calls for a determination by a physician, administrator, or judge; however, judicial review tends to be a slower process. For delusional patients and those affected by the Sell decision, no reliable differences were found between typical and atypical antipsychotics, or oral versus injectable administrations for the latter group, with respect to restoration. The medications utilized for incompetent for trial patients affected by the Sell decision, from most to least frequently prescribed, were haloperidol (41%) and risperidone (27%), followed by aripiprazole (13%), fluphenazine, ziprasidone, olanzapine, and quetiapine (all less than 10%), and finally clozapine (< 1%).

Most involuntarily medicated patients are restored (as are most voluntarily treated patients). Most incompetent for trial patients affected by the Sell decision are restored irrespective of primary or comorbid diagnosis and charge type. Plea-bargained conviction is the most common outcome following involuntary medication, but involuntary medication does not preclude a successful insanity defense. Lengthy continued hospitalization and release under Jackson seem to occur infrequently.

Ethical sources of authority
An annotation to Principle 7 (which concerns community improvement and public health betterment) of the Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry indicates that involuntary medication should be preceded by a personal examination of the patient and determination of incompetence for treatment decision-making. Another annotation encourages fostering cooperation among related disciplines and aiding the courts via communication. An annotation to Principle 4 (which concerns privacy and respecting the rights of others) mentions dangerousness but offers no guidance for involuntary medication.

The commentary accompanying the consent guideline in the American Academy of Psychiatry and the Law’s (AAPL’s) Ethics Guidelines for the Practice of Forensic Psychiatry provides that consent for forensic assessment is different from consent for forensic treatment, and that forensic psychiatrists should therefore be familiar with local patient treatment rights. The AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial raises the concern about conflicting roles (acting for the benefit of the patient but against his or her wishes regarding medication).

Professional practice sources of authority
The role of medications in restoring competence is widely acknowledged. While it has been observed that many patients who are civilly committed are nonetheless competent to make treatment decisions, this may apply less frequently to patients who are not competent to stand trial. This is clearly something that is assessed individually. For individuals who are incompetent to make such treatment decisions, a guardian or other substitute decision-maker is appointed. It is also noteworthy that medications are not appropriate for all patients (e.g., immature juveniles without mental disorders and individuals with intellectual disability and no comorbid mental disorders).

Psychiatric professionals confronted with involuntary medication in the context of the Sell decision should consider the nature of the primary diagnosis and any comorbid mental or physical disorders, any lengthy period of untreated psychosis, the potential impact of nonmedical interventions, any degree of success of prior psychopharmacological trials, and any history of serious adverse effects. Treatment steps in a Sell context can be considered sequentially:

1) Treatment-related assessment: diagnostic, functional, and prognostic considerations toward “medically appropriate” and “least intrusive means” decision-making

2) Intervention administration: general prescribing, adverse effect management, treatment decision-making competence, and dangerousness considerations toward “medically appropriate,” “trial rights infringement,” and “alternative grounds” decision-making
3) Follow-up: how to raise *Sell* decision concerns; recommended report contents, including attention to most of the *Sell* criteria; the inapplicability of alternative interventions; a treatment plan; and restoration maintenance considerations

**Recommendations for practice**
Psychiatric practitioners considering involuntary medication of patients who are incompetent to stand trial should thoroughly review the relevant clinical, ethical, and legal considerations described in this article and summarized in the Table. If such involuntary medication appears indicated after careful consideration, the decision will have incorporated the necessary components of a good decision under the circumstances.

**SIGNIFICANCE FOR THE PRACTICING PSYCHIATRIST**

**TABLE.** Practice recommendations regarding forced medication in patient...

**Disclosures:**
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**References:**


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