Dazed and Confused: Judiciary’s Role in Selling Psychotropic Drugs to Inmates and Detainees

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I. INTRODUCTION

The criminal justice system has become increasingly cognizant of issues presented by special populations, such as mentally ill pre-trial detainees and inmates.1 Additionally, there has been increasing concern with the quality of and access to services for mentally disordered offenders in both the nation’s jails and prisons.2 With this recognition has come the added realization that mentally ill offenders, or those presumed mentally

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disordered, are often denied some of the basic constitutional protections that are enjoyed by other more traditional criminal justice populations. Despite the long-standing tradition of the courts in imposing a special duty upon the states and the federal government to protect those in its custody, offenders with mental health problems continue to receive poor or inadequate care, they are disproportionately labeled as disciplinary problems, and they are disproportionately labeled as threats to the safety and security of jails and prisons.

Though these shortcomings are still pervasive throughout the various criminal justice arenas, mentally disordered offenders are not totally isolated from the protection of the Constitution. Specifically, mentally disordered offenders are said to retain a constitutionally protected liberty interest in their bodily integrity. Nevertheless, there have been numerous court challenges concerning the precise dimensions of this liberty interest,

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4. Cf. Youngberg v. Romero, 457 U.S. 307, 316-25 (1982) (recognizing that an essential feature of a legal duty arises when the state restricts the freedom or movements of individuals such as prisoners or other wards of the state).


especially as it relates to forcibly medicating mentally disordered offenders with psychotropic drugs.9 When this occurs, prison and jail officials claim that they have a duty to protect, treat, and supervise mentally disordered offenders.10 Nevertheless, legal advocates and other reformers are hesitant to ascribe such benign motives to the forcible injection of these drugs in view that psychotropic drugs can have both serious and long-lasting side effects.11 They view the forcible administration of psychotropic drugs as part of an ongoing attempt to undermine the principle of bodily integrity that carries with it the concomitant right to refuse psychotropic medication.12

The use and misuse of psychotropic drugs on inmates has been a very controversial practice. Among the issues that have been raised are: (1) whether the use of these drugs is an attempt to impose discipline; (2) whether prisoners pose a threat or danger to themselves or others in the institution; and (3) whether prisoners can challenge the decision that leads to the forcible administration of psychotropic drugs against their will.13 The confluence of these issues has resulted in two divergent bodies of law, one primarily concerned with issues related to offender dangerousness,14 and the other concerned with trial competence.15 This article will focus on this first strand of cases as it relates to the role of Justice Anthony Kennedy in framing the discussion of the right of inmates to refuse psychotropic drugs. Particular emphasis will be given to Justice Kennedy’s opinion in Washington v. Harper16 and his concurring opinion in Riggins v. Nevada.17 Both seem to reflect his uneasiness with allowing the needs of penal institutions to supersede the rights of inmates even when safeguards are put into place.18 Further, this article will discuss Justice Kennedy’s reluctance

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17. Riggins, 504 U.S. at 138.
to give states total freedom to determine the circumstances under which psychotropic drugs may be administered. The tensions reflected in Justice Kennedy’s decisions are part of a larger body of literature that has examined how state and federal courts, and the Supreme Court in particular, have tried to reconcile the issues of bodily integrity, the liberty interests of prisoners, and the needs of the prison.19 Prior to 1990, a number of decisions were made in both state and federal courts that grappled with psychotropic drugs and the right of prisoners to refuse them. Though there may have been mixed messages that came from these courts, they generally adhered to a principle wherein the right to bodily integrity could be constrained by the states’ police powers in emergencies.20 For example, courts in Wisconsin have adhered more to the principle of bodily integrity when rejecting requests by the state to forcibly administer psychotropic medications.21

II. GENERAL OVERVIEW OF PSYCHOTROPIC DRUGS AND THEIR SIDE EFFECTS

The use of antipsychotic drugs, also known as psychotropic drugs, began with the development of the drug chlorpromazine by a French scientist in the 1950s.22 The first generation of antipsychotic drugs included thorazine, halol, mellaril, and a number of other drugs that frequently arise in court cases.23 These first generation drugs are associated with numerous harmful side effects.24

Since the introduction of chlorpromazine, researchers have sought for more efficient antipsychotic drugs with fewer side effects.25 However, between 1975 and 1994, only two new drugs, clozapine and risperidone,
were approved by the Federal Drug Administration (FDA) for retail sale.\textsuperscript{26}

Since the 1990s, second generation drugs (also known as atypical antipsychotics) have grown in number to include olanzapine, quetiapine, and ziprasidone.\textsuperscript{27} Many of the negative side effects correlated with the first generation drugs do not manifest with the atypical drugs, although side effects remain.\textsuperscript{28}

Moreover, while much of the literature notes that the second generation drugs are more effective, increased effectiveness has only been documented for clozapine.\textsuperscript{29} While some of the atypical antipsychotics come with a significant reduction in extra-pyramidal side effects, some drugs (olanzapine, for example) continue to carry a risk of harmful side effects, including tardive dyskinesia.\textsuperscript{30}

Psychototropic drugs include both antidepressants and antipsychotic agents, and they are used for treatment of psychiatric disorders, depression, panic disorder, bipolar disorder, and perhaps even for the unseemly but expedient nonmedical purpose of controlling detainees and prisoners.\textsuperscript{31} Minor side effects of these drugs include fatigue, heart palpitations, blurred vision, and constipation;\textsuperscript{32} but Justice Kennedy’s concerns are directed at the more serious side effects, namely akathisia, acute dystonia, neuroleptic malignant syndrome, and tardive dyskinesia.\textsuperscript{33}

Akathisia gives the subject a feeling of distress and motor restlessness, or a compulsive desire to remain in constant motion.\textsuperscript{34} The side effect is one of the most difficult extra-pyramidal side effects to treat.\textsuperscript{35} Stephen Marder notes that “[e]ven mild involuntary movements can make patients appear odd or peculiar,”\textsuperscript{36} an observation that could lead to troubling results with respect to a jury’s impressions of a defendant.

\begin{itemize}
\item \textsuperscript{26} See id.
\item \textsuperscript{29} Martinez et al., \textit{supra} note 27.
\item \textsuperscript{30} Id.
\item \textsuperscript{31} Auerhahn & Leonard, \textit{supra} note 3, at 600-01.
\item \textsuperscript{32} Shagan, \textit{supra} note 3, at 267.
\item \textsuperscript{34} Martinez et al., \textit{supra} note 27; Stephen Marder et al., \textit{Physical Health Monitoring of Patients with Schizophrenia}, 161 AM. J. PSYCHIATRY 1334, 1342-43 (2004).
\item \textsuperscript{36} Marder et al., \textit{supra} note 34, at 1342.
\end{itemize}
Acute dystonia involves the involuntary and uncontrollable spasms of the upper body, tongue, eyes, face, and arms. Acute dystonia is ranked as "among the most disturbing and acutely disabling adverse reactions that can occur with the administration of antipsychotic drugs." Acute dystonic reactions can occur within hours of the first treatment.

Neuroleptic malignant syndrome is a rare but potentially fatal side effect characterized by muscular rigidity, hyperthermia, altered consciousness, tachycardia, and delirium. Rosenbush and Stewart note that patients experiencing neuroleptic malignant syndrome have “striking, frightening facial expression[s]” and suffer from an inability to speak and a “sense of impending doom.” Estimates of the frequency of the syndrome as a side effect of antipsychotic medication vary from .02% to 3.23%. For those who do get the syndrome, diagnosis and treatment can be difficult. Perhaps as many as 20% to 30% of those with the syndrome die from it, although Rosenbush and Stewart postulate that the mortality rate should be much lower with proper hospitalization and attention.

Tardive dyskinesia is, as Justice Kennedy notes in Harper, the most widely discussed side effect of psychotropic drugs. Tardive dyskinesia manifests with repetitive, purposeless, involuntary movements, particularly of the mouth, lips, tongue, and jaw, but it can sometimes affect the extremities and trunk as well. Cases of tardive dyskinesia may not manifest until after cessation of drug treatments, and can be irreversible. Furthermore, tardive dyskinesia is resistant to treatment with prophylactic drugs. Kessler and Waletzky estimate that 20% of chronic patients

37. Martinez et al., supra note 27, at 1088.
38. Id.
39. Id.
41. Rosenbush & Stewart, supra note 40, at 719.
43. Id.
44. Rosenbush & Stewart, supra note 40, at 719.
47. Kessler & Waletzky, supra note 40, at 206.
develop tardive dyskinesia, while Gardos and Cole suggest the number may be as high as 50%. However, Jeste, based on a meta-analysis of thirty-six studies, proposes that approximately 13% of chronically ill adults treated with neuroleptic drugs will suffer from the side effect.

Thus, the side effects of psychotropic drugs range from the minor and temporary to the significant, potentially irreversible, and occasionally deadly. These effects are pertinent to both the substantive liberty interest and constitutional trial rights which are implicated by the forcible administration of psychotropic drugs. Both the Harper and Riggins majorities recognized the sane individual’s liberty interest in being free from unwanted psychotropic medication. The importance of this liberty interest is underscored by the very real possibility that prisoners or pre-trial detainees may be subject to the foregoing debilitating side effects that could start immediately and last indefinitely. Moreover, the likelihood of experiencing one of the aforementioned side effects is substantial. For example, Keepers and Casey, in a study of sixty-two schizophrenic patients, found that 58% experienced either dystonia, parkinsonism, or akathisia upon taking neuroleptic drugs.

These side effects could negatively impact the right to a fair trial. A jury could easily make prejudicial inferences that the restless, fidgeting defendant (though he is suffering from akathisia) is nervous because he is

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49. Kessler & Waletzky, supra note 40.
51. See Jeste & Wyatt, supra note 46, at 297-309.
52. Other side effects include hypotension, arrhythmia, cardiovascular disease, and catorric reaction. See Rosenbush & Stewart, supra note 40, at 719; Kessler & Waletzky, supra note 40.
53. One of the side effects that has received less attention in the research literature pertains to the sexual dysfunction attributed to the use of these drugs. Sutha Murthy & Kevin R.Wylie, Sexual Problems in Patients on Antipsychotic Medication, 22 SEXUAL & RELATIONSHIP THERAPY 97, 99-101 (2007). The research that does exist suggests that the problems range from priapism, reduced libido, and erectile failure. Id. at 98-101. Moreover, this research suggests that these side effects are under-explored because of the sensitive nature of the issue. Id. at 101. Notwithstanding this fact, the sexual side effects of these drugs may likely provide an additional avenue into the courts. See id.
57. Id.
58. Id. at 86.
guilty.59 The jury might see the uncontrolled twitching or contorted facial expressions associated with tardive dyskinesia as a sign of unseemly and odd anti-social conduct.60 Importantly, the psychotropic drugs could inhibit the defendant’s ability to think clearly, make important trial decisions, and assist his counsel in the defense of his case.

A. Incremental Steps: Court Intervention and the Use of Psychotropic Drugs Prior to Harper

Prior to Washington v. Harper,61 there was little leadership from the Supreme Court, nor was there a uniform message at the state level regarding the forcible administration of psychotropic drugs to prisoners.62 Despite this fact, there were numerous state and federal cases that either attempted to provide a compelling rationale for restricting their administration or attempted to provide implications for the right to refuse the administration of psychotropic drugs.63 It was these early cases that laid the foundation for later courts to begin thinking about the contours of these prisoners’ liberty interests that should only be overcome by a showing of exceptional need by the state.64

59. In this regard, the inferences drawn by juries would be very different from those drawn by police officers who are trained to use unusual behavior as an indicia that a crime may be afoot. Juries, on the other hand, possess no similar training, thus, they may be more inclined to focus on non-legal or non-verbal cues to determine whether a defendant may be guilty or innocent. See Terry v. Ohio, 392 U.S. 1, 5-6 (1968); Bruce Darby & Devon Jeffers, The Effects of Defendant and Juror Attractiveness on Simulated Courtroom Trial Decisions, 16 SOC. BEHAV. & PERSONALITY 39, 48-49 (1988); Laurie Levenson, Courtroom Demeanor: The Theater of the Courtroom, 92 MINN. L. REV. 573, 582-83 (2008).

60. See Carolyn Lown, Legal Approaches to Juror Stereotyping by Physical Characteristics, 1 LAW & HUM. BEHAV. 87, 93 (1977).


62. A number of these early courts attempted to craft opinions that would accommodate the interests of both the state and inmates. See, e.g., United States v. Michigan, 680 F. Supp. 928, 980-81 (W.D.Mich.1987) (putting into play a monitoring system that would require prisoners to follow a strict drug protocol that required not only a medical evaluation before an inmate could be give psychotropic drugs but also documentation of all side effects and justification for any changes in drugs or dosages). These courts, however, seemed to be uncomfortable not only with the relative haphazard justifications given for using the drugs, but they were also concerned with the side effects of these drugs on inmates. Id. Thus, many courts mandated that specific protocols be followed if they were to be used. Id.

63. See, e.g., Bee v. Greaves, 744 F.2d 1387, 1395 (10th Cir. 1984) (noting that mentally ill pre-trial detainees retain the right to refuse psychotropic drugs except in the case of an emergency).

Rennie v. Klein\(^{65}\) was among the most influential cases decided during this early period. Rennie, a former pilot, began to develop mental problems after the death of his twin brother.\(^{66}\) Due to his deteriorating mental condition, Rennie made numerous visits to mental health hospitals; however, his twelfth admission, at which time he was diagnosed as both manic-depressive and suicidal, set the stage for the present case.\(^{67}\) As a precaution, Rennie was placed on both suicidal and homicidal watch.\(^{68}\) Though doctors at the hospital prescribed psychotropic medications, he refused to take them.\(^{69}\) As his condition further deteriorated, he was given injections of prolixin, yet there were still numerous reports from staff that he was extremely psychotic and threatened suicide.\(^{70}\)

For the duration of his commitment, the hospital never found Rennie to be incompetent. This “non-finding” proved to be the impetus for his lawsuit given that he believed that he was in the best position to determine whether to discontinue the administration of psychotropic drugs and whether they were beneficial.\(^{71}\) There were three main strands to Rennie's constitutional challenge. First, he asserted involuntarily committed mental patients still retained the right to refuse the forcible administration of psychotropic drugs.\(^{72}\) Second, he asserted the conditions under which he was committed were not sufficient to override his right to refuse medication.\(^{73}\) In other words, Rennie could only be forced to take

\(^{66}\) Id. at 1135.
\(^{67}\) Id. at 1136.
\(^{68}\) Id.
\(^{69}\) Rennie, 462 F. Supp. at 1135. As made clear in Bee v. Greaves, a state could overcome the right to refuse psychotropic drugs if it could demonstrate that its interests, presumably the prevention of harm to others, were furthered through the administration of psychotropic medications. 744 F.2d 1387, 1395-96 (10th Cir. 1984). In view that Rennie was deemed suicidal, the state could tether its argument favoring the forced administration of psychotropic drugs to the prevention of suicide. Rennie, 462 F. Supp. at 1135; see Rogers v. Okin, 478 F. Supp. 1342, 1365 (D. Mass. 1979) (finding that emergency situations may allow state institutions to override traditional due process concerns).
\(^{70}\) Rennie, 462 F. Supp. at 1135.
\(^{71}\) Id. at 1136.
\(^{72}\) Id. at 1144. This belief was grounded in the doctrine of privacy rights which had been extended to both medical and psychological decision making. Id. Among such protections are the right to protect one’s thoughts from government intrusion, which has been recognized by various courts including the Supreme Court of Hawaii. See Haw. Psychiatric Soc'y v. Ariyoshi, 481 F. Supp. 1028, 1048-50 (Haw. 1979). The only limitation that could be placed on such a right would entail an emergency situation that necessitated government intervention. See Rennie, 462 F. Supp. 1143-45. Here, no similar emergency situation was present.
\(^{73}\) See Rennie, 462 F. Supp. at 1144.
psychotropic drugs if he was deemed incompetent.\(^74\) Third, he asserted
doctors must use the least restrictive alternatives before pursuing a course
of treatment that included psychotropic drugs.\(^75\)

In addressing the first issue, the court attempted to balance the common
law proscription against involuntary medical treatment with the right to
privacy and personal autonomy in refusing medication.\(^76\) Additionally, the
court considered whether the right to privacy contained the constitutional
analog of the right to refuse treatment.\(^77\) These twin constructs were
grounded in the belief of autonomy over one’s body.\(^78\) In balancing these
factors, it was concluded that a patient’s autonomy interests could be
diminished or constrained only in emergency situations.\(^79\) Notwithstanding
this fact, the court found the state had several interests that could be
rationally promoted through the administration of psychotropic drugs.\(^80\)
Among these, a state’s police powers allowed it to confine and treat
patients who were a danger to themselves and to others.\(^81\) However, a
finding of dangerousness alone is not a sufficient justification for
involuntary treatment.\(^82\)

Additionally, the court found while states have a parens patriae interest
in securing treatment for those who are incompetent, a distinction should
be drawn between incompetence and mental illness.\(^83\) As such, there must

\(^74\) On this issue, Judge Brotman seems to have been persuaded by the doctors’ own
medical reports that suggested that Rennie responded better to treatment when he believed
he had “some real control over his fate . . . .” See Rennie, 462 F. Supp. at 1144-45.
Moreover, various courts have held that competent patients must give informed consent
before psychotropic drugs can be administered to them. See, e.g., United States v. Ballard,
704 F. Supp. 620, 627 (E.D.N.C. 1987) (upholding the right of individuals who were
deemed competent to refuse psychotropic drugs despite the state’s presumed interests);

\(^75\)  Rennie, 462 F. Supp. at 1146-47.

\(^76\)  Id. at 1144.

\(^77\)  Id.

\(^78\)  Id. at 1144-45.

\(^79\)  Id.

\(^80\)  Id. at 1145.

\(^81\)  Id.

\(^82\)  Various state courts have also found that security concerns alone are not a
sufficient justification for forcibly administering psychotropic drugs to mentally ill
prisoners. For example, the court in Large v. Superior Court, in and for Maricopa County
found that the bare assertion that there are security concerns involving a prisoner will not be
enough to justify suspending his due process rights. 714 P.2d 399, 407-08 (Ariz. 1986).
Absent an emergency surrounding some contemporaneous event, the due process rights of
inmates are at grave risk if the state is allowed to forcibly inject them with drugs. See id. at
408.

\(^83\)  See Rennie, 462 F. Supp. at 1145.
be a factual determination that a patient is incompetent before psychotropic medication can be involuntarily administered. Such incompetency determinations must assume the form of a hearing during which a fact finder must determine whether some underlying mental illness precipitated the refusal to take the medication, or whether there was some other rational objection to the medication.

During this fact-finding process, there also must be a determination of whether the patient understood the nature and extent of his mental problem. Further, there must be a finding that the patient understood the link between the medication, treatment, and a refusal to take the medication.

The patient's refusal to take the medication could be overridden only if there was a finding that his "diminished capacity" rendered him unable to objectively understand the interplay between these three factors and the ability (or inability) to care for himself.

84. See id. at 1146; see also United States v. Elmers, No. 2006 WL 2375635, at *9-10 (D. Minn. 2006) (ruling that there must be sufficient evidence to support an allegation that an inmate has a mental condition that requires treatment, without which he would pose a danger to himself or others in the facility).

85. See Rennie, 462 F. Supp. at 1146.

86. It is noteworthy to point out that some courts have held that psychotropic drugs can be used over the objection of inmates if the prescribing psychiatrist makes a determination that they are too incompetent or "disabled" to exercise reasonable judgment regarding their safety. Under such circumstances, psychotropic drugs can be forcibly administered for a period of time not to exceed ninety-six hours. See Cliff v. Warden, State Prison, No. 88-0000455, 1990 WL 279544, at *1, 3 (Conn. Super. Ct. Sep. 7, 1990).

87. There are instances when courts have allowed these drugs to be used even when the connection between them and the necessity for their use escapes the comprehension of inmates. For example, in Gilliam v. Martin, a court held that despite the fact that an inmate never recognized that the drugs had a positive effect on him and his behavior, they could nevertheless be used because the medical personnel in the prison had documented the rather dramatic changes, oftentimes violent, in the inmate when he was taken off the medications. 589 F. Supp. 680, 682 (W.D. Okla. 1984).

88. See Rennie, 462 F. Supp. at 1146. Interestingly, research indicates the medical staff that is responsible for administering these drugs may not fully understand the impact on the body and the adverse side effects that typically accompany the drugs. For example, a study conducted by Fretwell and Felce in 2007 found that community nurses possessed limited knowledge about antipsychotic drugs, and few were given training relative to the identification of their side effects. Christine Fretwell & David Felce, Staff Knowledge of the Side Effects of Anti-Psychotic Medication, 20 J. APPLIED RES. IN INTELL. DISABILITIES 580, 583-84 (2007). Given this finding, courts may be making an unwarranted assumption that the medical staff is in a position to inform patients or inmates about the connection between antipsychotic drugs, their mental condition, and why the drugs are necessary. Id. Consequently, the staff may be in no better position to make determinations about the efficacy of antipsychotic drugs than are patients and inmates themselves. Id.
The court found the least restrictive alternative must be employed before a hospital could resort to forced administration of psychotropic drugs.\textsuperscript{89} That is, alternative treatments must first be used before a patient’s wishes could be disregarded.\textsuperscript{90} Thus, psychotropic drugs can be used only as a last resort. Given this criterion, the court held while some treatment modalities may not be successful, there may be other available alternatives that are less intrusive.\textsuperscript{91} For example, the court pointed out the efficacy or effectiveness of different treatments could be evaluated only over a prolonged period of time.\textsuperscript{92} As such, psychotropic drugs should not be used simply because some previous form of treatment did not meet with immediate success.\textsuperscript{93}

Even though it was determined Rennie retained a liberty interest in being free from forcible medication, this liberty interest could be restricted upon a finding of dangerousness and incompetence.\textsuperscript{94} However, the court’s opinion lacked one critical component: it failed to provide any guidance relative to how “dangerousness” should be defined.\textsuperscript{95} One could argue this failure to provide a standard allows for a greater level of state intrusion into the realm of privacy that the court believed to be fundamental.\textsuperscript{96} Moreover, it could be argued this failure to provide a standard allows the state to make subtle yet arbitrary distinctions without regard to the autonomy interest of patients. The saliency of these deficiencies is magnified by the fact that the court did not suggest a standard that could be used to evaluate the nature and extent of “emergency situations.”\textsuperscript{97}

Using this reasoning, “emergency situations” could presumably reach many protected spheres of liberty and even potentially extend beyond the

\textsuperscript{89} See Romeo v. Youngberg, 644 F.2d 147, 173 (3d Cir. 1980). Some courts have held that a “least intrusive” analysis should be conducted where there is a possibility that serious side effects could result from a particular course of treatment. Id. at 166. Where such side effects exist, courts have reasoned that the “least intrusive” means to achieve a state’s goal have not been achieved. Id.

\textsuperscript{90} Id.

\textsuperscript{91} Id. at 166-67.

\textsuperscript{92} Id.


\textsuperscript{94} Id.

\textsuperscript{95} It should be noted that it was not unusual for federal courts to broadly characterize dangerousness along the following continuum: individuals must be a danger to themselves or a danger to others. See Davis v. Hubbard, 506 F. Supp. 915, 935 (Ohio 1980). Defining the contours or parameters of this continuum was generally left to the discretion of government officials. Id.

\textsuperscript{96} In Rivers v. Katz, for example, the court was disturbed by the fact that an “emergency situation” could potentially be of indefinite duration. 495 N.E.2d at 344-45.

\textsuperscript{97} Id.
immediate need for the intervention of state police power. Despite these perceived shortcomings, the court’s opinion did provide a framework for later cases to follow. Kennedy’s emphasis on making findings based on dangerousness, emergencies, and incompetence guided the decisions of other judges who addressed this issue, particularly as illustrated by Rogers v. Commissioner of Department of Mental Health. The plaintiffs, all of whom had been committed to the state hospital, alleged the hospital forcibly medicated them against their will. In arriving at its decision, the Supreme Judicial Court of Massachusetts found that the State must meet certain conditions before it could compel a patient to take psychotropic medications. First, the court determined there must be a finding that the patient poses a serious likelihood of harm. Though not exactly synonymous with dangerousness, this requirement provides a framework for understanding that harm encompasses both a physical dimension, such as threats and violence directed at others or oneself, as well as a psychological dimension, which includes mental conditions that worsen over time such as schizophrenia. The court’s use of this term belies the fact that harm can manifest through serious bodily injury to oneself or threats of serious bodily injury upon others.

Second, the court determined harm can manifest by a patient’s inability to care for or protect himself in the community. Only after such findings had been made could the state override a patient’s decision to refuse

98. Cf. Jones v. Chandra, 2007 WL 1320742; Knight v. Kamal, 2006 WL 2376918; Chapman v. Haney, 2004 WL 936682; Dancy v. Simms, 116 F. Supp. 2d 652, 654-55 (D.M.D. 2000); Chambers v. Ingram, 858 F.2d 351, 359-60 (7th Cir. 1988); United States v. Charters, 829 F.2d 479, 492 (4th Cir. 1987). Concerns about what constitutes an “emergency” has in fact materialized in legal claims filed against prisons and hospitals which alleged that forced medication with psychotropic was used not for legitimate emergency reasons but rather they were used as retaliation or punishment for some illegitimate or manufactured wrong committed by an inmate or patient.


100. Id. at 311.

101. Id. at 310.

102. Id. at 312-14.

103. Id. at 312-13. Prior threatening behavior was sufficient to make a finding of harm. Id. While some courts subscribe to the general presumption that the state’s interest in preventing harm to others may outweigh the interests of an inmate or mental patient, many nevertheless believe that an opportunity should be provided to the inmate or patient to rebut any such presumption in a hearing under appropriate circumstances before psychotropic drugs can be administered. This position has been advanced in Davis v. Hubbard, 506 F. Supp. 915, 935 (N.D. Ohio 1980), Keyhea v. Rushen, 178 Cal. App. 3d 526, 534-36 (1986), and Preston v. Gutierrez, 1993 WL 280819, at *14 (W.D. Mo. July 23, 1993).

Importantly, the court made the point that a finding of harm does not mean that a patient is incompetent. Additionally, the court pointed out that involuntary commitment is not the equivalent to a finding of incompetence. In making this finding, the court reasoned, "a person committed to a mental institution may still be competent enough to manage his personal affairs." As such, the state has no power to make treatment decisions on the patient's behalf until there has been a finding of incompetence. The court's reasoning intersects with *Rennie v. Klein* where the court believed that it was critically important that a patient not lose the right to make decisions for himself until he has been deemed incompetent through appropriate judicial proceedings.

Also noteworthy, the court in *Rogers* addressed which state interests are implicated when one seeks to circumvent the due process rights of mental patients. The court held the state's police powers were not broad enough to compel medication unless there was a threat of "imminent harm." This finding comports with *People v. Medina*, in which the Colorado Supreme Court held determinations of dangerousness must be based on the imminent threat of harm. Further, this finding of "imminent harm" affirms the *Rennie* court's holding that a state's police power can be invoked only in emergency situations. Other courts followed suit. For example, in *Walters v. Western State Hospital*, the court stated harm or danger must be imminent rather than merely conjectural. Moreover, the anticipation of harm at some future time is not sufficient to override a patient's refusal to take medication.

Moreover, the state must pursue alternative measures before resorting to the use of psychotropic drugs; this requirement can be overcome by a finding that medication is needed to prevent substantial and irreversible mental deterioration. Thus, the *Rogers* decision mirrors *Rennie* to

106. *Id.* at 312.
107. *Id.* at 314.
108. *Id.*
109. *Id.*
111. *Id.* at 321-22.
112. *Id.*
113. 705 P.2d 961, 973-74 (Colo. 1985).
115. 864 F.2d 695, 697-98 (10th Cir. 1988).
116. *Id.* at 699-700.
118. *Id.*
the extent that psychotropic drugs should be viewed as the option of last resort.

Though these decisions may demonstrate the various courts’ unwillingness to entirely divest mental patients, inmates, and pre-trial detainees of their liberty interests, they nevertheless point out that these liberty interests must be balanced against the interests of the state. As such, the state must make a showing of dangerousness or incompetence.\textsuperscript{120} Though these developments led to a number of challenges, courts in other jurisdictions nevertheless seemed to signal a retreat from closely scrutinizing the use of psychotropic drugs, particularly in the Eighth Circuit, as it related to prison inmates.\textsuperscript{121}

In the Eighth Circuit an inmate challenged the doctors’ policy of forcible injection of psychotropic drugs to disruptive inmates.\textsuperscript{122} The inmate, Lappe, refused medications on several occasions, but he would later relent and cooperate.\textsuperscript{123} Ultimately, Lappe was involved in a physical altercation with prison staff, whereupon he was restrained and medicated.\textsuperscript{124} This incident gave rise to his challenge of the prison policy.\textsuperscript{125} The court, while not holding Lappe’s liberty interests were extinguished, ruled his subsequent transfer back into a prison environment changed his status such that a doctor could not treat him with psychotropic medications unless he was in state custody.\textsuperscript{126} While recognizing that prisoners in full state custody could not be forcibly medicated, the court held that Lappe could not simultaneously be classified as having outpatient status.\textsuperscript{127} Consequently, provisions under Chapter 229 of the Iowa Code were not written to permit a treating physician’s medication orders to be extended to prison settings.\textsuperscript{128}

\begin{itemize}
\item \textsuperscript{120} See Rogers, 458 N.E.2d at 321.
\item \textsuperscript{121} See Lappe v. Loeffelholz, 815 F.2d 1173, 1179-80 (8th Cir. 1987).
\item \textsuperscript{122} Id. at 1175.
\item \textsuperscript{123} Id.
\item \textsuperscript{124} Id.
\item \textsuperscript{125} Id.
\item \textsuperscript{126} Id. at 1179.
\item \textsuperscript{127} Id.; see Baugh v. Woodard, 808 F.2d 333, 333-34 (4th Cir. 1987). In some instances, courts have held that an inmate has suffered no due process injury where he is given a hearing after a transfer to a prison mental health facility has been approved but before his admission has been completed and prior to any course of mental health treatment including the forcible injection of psychotropic drugs. Id.
\item \textsuperscript{128} See generally Washington v. Harper, 494 U.S. 210 (1990). More generally, several other legal challenges were brought against state prison officials from administrating psychotropic drugs to inmates absent a “true emergency.” See Lappe v. Loeffelholz, 815 F.2d 1173, 1178 (8th Cir. 1987). Statutes implicated in several other legal challenges were: ARIZ. STAT. ANN. § 31-226 (1984); CAL. PENAL CODE § 2600 (West 2000); IOWA CODE ANN.
Collectively, one could argue these cases seem to have cleared the way for both involuntarily committed patients and prison inmates to refuse psychotropic medications. Further, one could argue these cases do not permit state interests to override the right to refuse these medications except within a very narrow range of exceptions. In spite of the constitutional significance that these courts have given to an inmate’s liberty interest, challenges continued to be pursued against both prisons and mental health hospitals. It was not until 1990 that the U.S. Supreme Court weighed in on the issue.

III. THE WATERSHED DECISIONS

In Washington v. Harper, the Supreme Court addressed the right of prison inmates to refuse psychotropic drugs for the first time. The Court’s primary focus in this case was not whether inmates have a right to refuse these medications, but what process was due to inmates who so refused.

Harper, an inmate convicted of armed robbery, had been receiving psychiatric treatment, which included the consensual injection of psychotropic drugs. His violent behavior, however, required that prison officials transfer him to a special treatment unit for offenders with psychiatric problems, where he could be monitored and, if necessary, receive medication in furtherance of this policy.

Harper was required to take medication, but he refused. This refusal served as the basis for his lawsuit in which he claimed that he was denied due process.

After his claim was rejected by the Superior Court, he renewed this contention in the State Supreme Court, which found not only did Harper retain a liberty interest in refusing psychotropic drugs, but his due process rights were also violated. Later, the U.S. Supreme Court attempted to resolve this very important issue.

REV. § 229.6 (West 2008).

129. A number of federal courts subsequently noted the conflict in interpreting the law across the circuits as it related to the forcible administration of psychotropic drugs. Sullivan v. Flannigan, 8 F.3d 591 (Ill. 1993) (holding that inmates are not denied due process so long as they are allowed to participate in a hearing to determine whether psychotropic drugs are necessary to their continued welfare and safety). It matters not that the inmates are still on drugs at the time the hearing actually occurs. See id. at 598-99.


131. Id.

132. Id.

133. Id.

134. Id.

135. Id. at 210-11.
Justice Kennedy, writing for the Court, held Harper’s due process rights were not violated. He found the policy of the Special Offender Center comporting with due process on several grounds. First, he reiterated the point that psychotropic drugs could only be administered if there had been a previous finding that the prisoner was mentally disabled and posed a danger to himself or to others. Second, he found the policy allowed redress because the prisoners were given the opportunity for a hearing, notice, and a right to present evidence on one’s own behalf including calling witnesses and assistance by an advisor. This reasoning became the standard that was later adopted by various lower courts, especially the Fourth Circuit.

Justice Kennedy, as did courts before him, paid particular attention to the state’s interests that were in question. Unlike previous courts, however, he did not subscribe to the notion that one’s liberty interest in being free from forced medication was a right that outweighed the state’s interests in safety. Instead, he found the state’s interest in prison safety and security was just as important as any liberty interest possessed by prison inmates. The uniqueness of the prison environment made it necessary for the state to have methods at its disposal to confront and quickly address the myriad of problems posed by such a special population. This point is made quite salient where Justice Kennedy declared that “[t]here are few cases in which the state’s interest in combating the danger posed by a person to both himself and others is greater than in a prison environment, which, ‘by definition, is made up of persons with a demonstrated proclivity for antisocial criminal, and often violent conduct.’” Consequently, the presumed liberty interest of prisoners in being free from forced medication must take a back seat to the legitimate interests of the state where a special

136. Id.
137. Id. at 215.
138. Id. at 216.
142. Id. at 226-27.
143. Id.
population of offenders poses a danger to others and prison staff.\textsuperscript{144}

Justice Kennedy next addressed whether the policy of the Special Offender Center comported with Due Process. He found the policy did in fact further the state’s interests, without failing to accord prisoners their full panoply of rights.\textsuperscript{145} The policy, according to Justice Kennedy, set a rather high standard insofar as the state could not needlessly medicate prisoners without some kind of oversight by trained professionals.\textsuperscript{146} Here, two concerns guided Justice Kennedy: he believed that the Court should not second-guess doctors but rather they should defer to their judgment and he was apprehensive of excessive entanglement of the Court in prison affairs.\textsuperscript{147} This observation may be the reason why Justice Kennedy suggested that scarce prison resources could be better spent elsewhere.\textsuperscript{148} Even more, the prisoners facing forced medication were given a myriad of protections, not unlike those that had been approved by a federal court in Rogers v. Okin,\textsuperscript{149} including: (1) the right to appeal determinations of the policy committee; (2) notice of committee decisions; (3) the ability to present evidence on their own behalf at an adversarial proceeding; and (4) the ability to call witnesses.\textsuperscript{150} Moreover, Justice Kennedy believed the judicial review provision that was put into place was sufficient to protect the liberty interests of prisoners facing forced medication.\textsuperscript{151} Given these facts, the Court found Harper’s due process rights were not violated.\textsuperscript{152}

While the Harper decision did not turn back the clock with regard to prisoners’ liberty interests in being free from forced medication, this opinion certainly cannot be hailed as a victory. There may be two bases for this concern. First, the Court gave only cursory attention to whether prisoners lose their right to be free of psychotropic drugs. Justice Kennedy himself recognized the harmful effect of these drugs but he dismissed this concern in favor of furthering the state’s penological interests.\textsuperscript{153}

\begin{thebibliography}{9}
\bibitem{144} Id. at 227.
\bibitem{145} Id. at 228.
\bibitem{146} Several challenges have evolved from concerns involving the misuse of psychotropic medication and concerns that the use of this medication could potentially be of unlimited duration. See Sullivan v. Flannigan, 8 F.3d 591, 592 (7th Cir. 1993) (calling attention to the troubling nature of this specter but nevertheless believed it to be permissible); see also Coleman v. Wilson, 912 F. Supp. 1282, 1283 (E.D. Cal. 1995); Nelson v. Heyne, 355 F. Supp. 451, 455 (N.D. Ind. 1972).
\bibitem{148} Id. at 232.
\bibitem{149} 738 F.2d 1, 6-7 (1st Cir. 1984).
\bibitem{150} Harper, 494 U.S. at 235.
\bibitem{151} Id. at 235-36.
\bibitem{152} Id.
\bibitem{153} Jeanette Brian, The Right to Refuse Antipsychotic Drug Treatment and the
Moreover, he seemed to premise his decision on the belief that the benefits that accrue to the state through use of these psychotropic drugs outweigh their negative side effects. Though it certainly cannot be said that Justice Kennedy condoned the arbitrary use, and sometimes misuse, of psychotropic drugs, his opinion does call attention to the fact that these drugs can be used as a means of maintaining control within the prison environment rather than serve a true rehabilitative purpose.\(^{154}\)

Second, the Court’s deference standard is arguably problematic to the extent that there seemed to be a willingness to ascribe undue deference to the decisions of prison administrators and prison doctors.\(^{155}\) Justice Kennedy’s endorsement of a “hands-off” approach by the courts is most notable where he writes “we do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing.”\(^{156}\) Nevertheless, an argument could be made that the interests of prisoners are best served through judicial oversight.\(^{157}\) This is not to suggest that courts should micro-manage prisons and the everyday decisions that are made within them, but rather courts should maintain an ongoing role in the prisons, lest abuses and tragedies of the past be repeated.

The Supreme Court next addressed the issue of forcible administration of psychotropic drugs in *Riggins v. Nevada*.\(^{158}\) Riggins, a pre-trial detainee awaiting trial on murder charges, was given an antipsychotic drug because he complained of hearing voices.\(^{159}\) He later made a motion to have the administration of the drug suspended during his trial because he feared that it would have an adverse effect on his demeanor and his ability to assist his attorney.\(^{160}\) Riggins argued he was entitled to show the jury his true demeanor because he was asserting an insanity defense.\(^{161}\) However, this

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156. *Id.* at 232.


159. *Id.* at 129.

160. *Id.* at 130.

161. *Id.* This same issue has arisen on a number of occasions where defendants claim
motion was denied without comment by the court.\textsuperscript{162} Importantly, the judge hearing the motion based his opinion on a report that “guessed” there would be no noticeable difference in Riggins whether he was on or off the medication.\textsuperscript{163} Riggins proceeded to trial and was found guilty.\textsuperscript{164}

This decision was appealed to the Nevada Supreme Court, where Riggins argued that his defense had been compromised.\textsuperscript{165} He also argued he was not able to present a complete defense because of the side effects of the medication.\textsuperscript{166} The Nevada Supreme Court upheld his conviction, and he sought relief from the U.S. Supreme Court.\textsuperscript{167} Justice O’Connor, writing for the Court, used the language in \textit{Washington v. Harper}\textsuperscript{168} as the basis for the opinion.\textsuperscript{169} In noting that the state could involuntarily medicate Riggins if it was demonstrated that it was necessary for his safety and that of others, akin to the showing required in \textit{Cochran v. Dysart},\textsuperscript{170} Justice O’Connor found the state made no such threshold showing.\textsuperscript{171} A similar point was made in her concurrence in \textit{Foucha v. Louisiana}; she pointed out the contours of detention are defined “to reflect the pressing safety concerns related to [an] acquitee’s continuing dangerousness.”\textsuperscript{172}

Justice O’Connor, like Justice Kennedy before her, stressed the fact that psychotropic drugs and other forms of restraint should only be administered against the will of detainees where their dangerousness is apparent and it poses a threat to public safety.\textsuperscript{173} Finally, Justice O’Connor

\begin{footnotes}
\item[162] \textit{See Riggins}, 504 U.S. at 130.
\item[163] Research studies have consistently shown that psychotropic drugs produce noticeable effects in the persons to whom they are administered. \textit{See generally} Jeste \& Wyatt, \textit{supra} note 46.
\item[165] \textit{Id.} at 131.
\item[166] \textit{Id.}
\item[167] \textit{Id.} at 132.
\item[169] \textit{See Riggins}, 504 U.S. at 135.
\item[170] 965 F.2d 649, 650-51 (8th Cir. 1992).
\item[171] \textit{See Riggins}, 504 U.S. at 135.
\item[173] \textit{See Riggins}, 504 U.S. at 134-35.
\end{footnotes}
found that Riggins' liberty interest in freedom from unwanted medication had not been properly weighed by the lower court, especially in view that the dosages of medication that were routinely prescribed by the doctors were within the toxic range. Last, the pronounced side effects caused by the medications and their likely impact on Riggins and his presentation of a defense simply could not be discounted. Thus, in her opinion, courts must balance the effects of the medication against the possibility that one's defense could be prejudiced. To do otherwise would almost certainly infringe upon a constitutionally protected right.

Justice Kennedy's concurring opinion provides an interesting contrast to the reasoning used by Justice O'Connor because he seems to rethink his prior position in Washington v. Harper; he entertains the possibility that the state will misuse psychotropic drugs if there is no oversight from the courts. Justice Kennedy first called attention to the fact that the state in this case was not seeking to minimize harm or danger that could be caused by Riggins. Rather, the state's interest was centered solely on rendering him competent to stand trial. In this regard, Justice Kennedy believed that the state had the burden of demonstrating the administration of the medications would neither impair, alter, nor affect his ability to assist in his defense. Shifting the burden to the state in this manner was no different from what other courts have required of the state.

For example, in Woodland v. Angus, the court held that the state's interest in administering psychotropic drugs to a detainee to render him competent for trial was not sufficient to override his liberty interest in bodily autonomy. As such, the state of Nevada failed to carry this burden.

Additionally, Justice Kennedy expressed concerns about the side effects of the drugs, unlike some prior courts that seemed to diminish the significance of arguments that presumed that these drugs altered the behavior of patients and detainees.

For example, one court commented that "[t]o order [a] trial court to force a [patient] to stop taking medications that were prescribed for him in the legitimate course of treatment . . . simply to see what he would say if he

174. Id. at 137.
175. Id.
177. See Riggins, 504 U.S. at 141.
178. Id.
179. Id. at 139-40.
180. Id. at 142-44.
182. Riggins, 504 U.S. at 142.
went untreated—would be a bizarre way to vindicate the Due Process Clause.183

While Justice Kennedy's reasoning was not so apparent in *Washington v. Harper*, he now seemed to be signaling that antipsychotic medications could affect one’s demeanor, despite the fact that in his prior opinion did not address concerns that these medications could affect the appellant or impair his ability to mount a proper defense.184 Justice Kennedy's new position seemed to rely more on medical studies showing that "[t]he side effects of antipsychotic drugs can hamper the attorney-client relation, preventing effective communication and rendering the defendant less able or willing to take part in his defense. The state interferes with this relation when it administers a drug to dull cognition."185 The reasoning used by Justice Kennedy here should have applied equally to Harper, who was tasked with calling witnesses and assisting his lay advisor who was not a trained attorney. One would argue that the stakes were higher in *Harper* in view that antipsychotic medications could conceivably have been forced upon him for an indefinite period of time. Some courts, such as the Southern District of California in *United States v. Sanchez-Hurtado*, have in fact endorsed such a proposition.186 Thus, Harper and inmates who are similarly situated would need more protection from the state than what they were given. Justice Kennedy seems to have belatedly recognized that these medications are more of a burden rather than a benefit.187

A. “Rewriting” *Harper* and *Riggins*

While the U.S. Supreme Court was deciding cases like *Riggins*,188 there was increasing activity in the federal courts concerning issues related to whether prisoners and pre-trial detainees could refuse antipsychotic drugs.189 Many of these cases focused on whether these medications could be given solely for the purpose of rendering detainees competent to stand trial. One such case was *Khiem v. United States*, where the D.C. Court of Appeals confronted whether the government’s interest in bringing Khiem to trial outweighed his liberty interest in being free of antipsychotic drugs.190 Khiem, a pre-trial detainee who was held for the murder of a

185. *Id.* at 144.
prominent Vietnamese couple, challenged a trial court’s decision authorizing the use of psychotropic drugs.191 Khiem had initially been adjudged as competent to stand trial, but his conduct during the course of the trial became so bizarre that the trial proceedings were suspended so psychiatrists could evaluate him.192 After psychiatrists found him to be incompetent, the trial judge ordered a mistrial and committed Khiem for treatment and evaluation.193

Over the course of two years, psychiatrists repeatedly diagnosed Khiem as incompetent yet advised the judge that he should not be forced to receive psychotropic drugs.194 After prosecutors filed a motion was filed to terminate Khiem’s commitment, a follow-up psychiatric report was issued by a new psychiatrist who recommended Khiem receive treatment with psychotropic drugs as a means of rendering him competent for trial.195 The other psychiatrists opposed any attempt to medicate him solely for trial purposes, yet prosecutors asked the trial court not to follow the advice of these professionals. After a hearing, the trial judge found the arguments of the government to be persuasive and he ordered the drugs be administered to Khiem.196

The D.C. Court of Appeals affirmed the decision of the trial court.197 In addressing Khiem’s claim that the forcible administration of psychotropic drugs violated his liberty interest in bodily integrity, the court held that the government had a legitimate interest in bringing him to trial.198 The court also found that while Khiem’s right to be free from these drugs was not lost when he was committed, the government had an equally compelling interest in ensuring that he was tried before a jury for the crimes that he committed. The court’s main concern was whether Khiem could be brought to trial at all if his profound mental condition did not improve.199 When the need for punishment for the crime was balanced against incapacitation, Khiem’s liberty interest had to give way to the government’s interests.200

The court also addressed Khiem’s due process arguments.201 In

191. Id. at 163-64.
192. Id. at 162.
193. Id.
194. Id.
195. Id. at 163.
196. Id.
197. Id. at 162.
198. Id. at 167.
199. Id. at 166-67.
200. Id.
201. Id. at 171. Additionally, a number of scholars have commented on the range of due process rights (trial rights) that are implicated in the forcible administration of psychotropic drugs. M. Catherine Healy, Riggins v. Nevada: Are “Synthetically Sane”
addressing these claims, the court first reaffirmed the “deference to professionals” standard proposed by Justice Kennedy in Washington v. Harper.\(^2\) Second, the court found no fault in the administrative procedures used by the hospital relative to involuntarily medicating patients.\(^3\) According to the court, the proper reading of Washington v. Harper suggests that an adversarial hearing is not required to protect the rights of a detainee.\(^4\) Moreover, the court found that the lay advocate provided by the hospital is more than sufficient to protect one’s liberty interests.\(^5\) Third, the court found the hospital’s decision to medicate is consistent with the balancing approach used by the Supreme Court in Harper and also other federal courts wherein the state’s interests must be accorded considerable weight in making determinations to medicate detainees.\(^6\)

While this court may have believed its opinion was in line with the logic of Washington v. Harper,\(^7\) one could argue that it actually takes a much narrower view of Justice Kennedy’s position. First and foremost, Justice Kennedy expressed the view that one’s liberty interest in avoiding the administration of these drugs was important unless there was “a valid, rational connection between the regulation and the legitimate governmental interest put forward to justify it.”\(^8\) Notwithstanding the importance of this “rational connection,” the court in Khiem and others like it,\(^9\) have held that a specific or direct finding of dangerousness is not required under Harper if other compelling state interests are at stake.\(^10\) The record before the court in Khiem did not suggest that such a danger or harm was present. While one readily concedes that he was convicted of homicide, it is still arguable whether his past crime was an adequate indicator or predictor of

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\(^2\) 494 U.S. 210, 231 (1990) (“We conclude that an inmate’s interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge.”); see also United States v. McAllister, 969 F. Supp. 1200, 1213 (D. Minn. 1997).


\(^4\) 494 U.S. at 233.

\(^5\) Id. at 236.


\(^7\) 494 U.S. at 227.

\(^8\) Id. at 224. This framework has been adopted by a number of courts including Doe v. Dyett, 1993 WL 378867, at *2 (S.D.N.Y. 1993).


\(^10\) Id.
his present or future dangerousness. This reasoning is analogous to the model that has been followed in some Massachusetts courts, which have held that current incapacity must be the basis for a finding of incompetence and dangerousness. The court in Khiem, however, seemed to infer dangerousness from his past acts rather than any present evidence that he posed a threat of danger. Moreover, the reasoning used by the court seems contrary to Fouche v. Louisiana where the Supreme Court held the detention scheme used by the state of Louisiana was not constitutionally sound because there had been no findings of dangerousness. This point becomes even more salient in light of the fact that the psychiatric reports never made a finding that he was dangerous. As such, it could be argued that the court substantially altered the essence of Justice Kennedy’s reasoning in the Harper decision.

Second, it seems that the Khiem court overlooked the Supreme Court’s decision in Riggins v. Nevada, where Justice Kennedy’s concurring opinion indicated that there must be a “sound medical basis” for the injection of antipsychotic drugs. Justice Kennedy’s primary concern was whether the state would use such drugs solely for the purpose of bringing someone to trial.

This concern has also been mirrored in other state and federal courts. For example, in State of Louisiana v. Perry, the Supreme Court of Louisiana held that the state could not administer psychotropic drugs to a convicted murderer solely for the purpose of carrying out his death sentence. Such a purpose, in the view of Justice Kennedy and other judges, is illegitimate.

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211. Other courts have held that a finding of dangerousness must precede the forcible administration of psychotropic drugs. See Enis v. Dep’t of Health and Soc. Res. of the State of Wis., 962 F. Supp. 1192, 1194 (W.D. Wis, 1996) (“Plaintiff has a liberty interest in avoiding the forced administration of psychotropic drugs without a preceding determination that he is dangerous to himself or others and that administration of drugs is in his best medical interest.”). In other words, some sort of hearing must first take place before these drugs can be authorized for use over the objections of an inmate or patient, and where it is unclear that such drugs are in his best medical interests. Id.


217. Id.

218. 610 So.2d 746, 758 (La. 1992) (“When antipsychotic drugs are forcibly administered to further the state’s interest in carrying out capital punishment, and therefore not done in the prisoner’s best medical interest, the intrusion represents an extremely severe interference with that person’s liberty.”).

219. Id.
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By analogy, one could argue that the same level of concern should have been shown relative to the manner in which Khiem was "rendered competent."220 He was given psychotropic drugs not as treatment and certainly not to render him harmless.221 Rather, "the avowed purpose of the medication [was] not [to help him achieve] functional competence, but competence to stand trial."222 In light of this fact, the purported interest advanced by the state should have been deemed a lesser right when juxtaposed against Khiem's rights to be free from psychotropic medication.

Last, concerns are raised, not unlike those raised by Justice Kennedy in Riggins v. Nevada about the level of assistance that Khiem would be able to provide to his advocate given that he was under the influence of psychotropic drugs.223 It is quite likely that Khiem's effectiveness in helping the advocate prepare for his hearing was greatly diminished because of the side effects of the drugs.224 This concern seems to have escaped the attention of the court.

B. Unearthing the Interconnected Pillars Supporting the Right to Refuse Psychotropic Drugs

When noting in Harper the "substantial interference" that forcible medication of antipsychotic drugs has on a prisoner's liberty interest, Justice Kennedy pays special attention to the side effects of antipsychotic drugs.225 The majority opinion specifically mentions acute dystonia, akathesia, neuroleptic malignant syndrome, and tardive dyskinesia.226 The Court nevertheless concludes that a prisoner's liberty interest—even considering these deleterious side effects—may satisfactorily be protected under the scheme set forth by the Harper opinion.227 In Riggins, Justice Kennedy's concurrence reveals a deep concern with the "serious threat" that forcible administration of antipsychotic drugs poses to a defendant's right to a fair trial.228 Thus, the liberty interest enunciated in Harper is

221. Id.
222. Id. at 161. See generally Keith Byers, Incompetence, Execution, and the Use of Antipsychotic Drugs, 47 ARK. L. REV. 361 (1994); Brian Domb, A New Twist in the War on Drugs: The Constitutional Right of a Mentally Ill Criminal Defendant to Refuse Antipsychotic Medications that Would Make Him Competent to Stand Trial, 4 J.L. & HEALTH 273 (1990).
224. Khiem, 612 A.2d at 173.
227. Id. at 231.
228. Riggins, 504 U.S. at 138.
coupled with a new worry over the implication of the side effects; not only is there a liberty interest, but now also a possibility that the various side effects of psychotropic drugs might deprive a defendant of his or her Sixth Amendment right to assistance of counsel, the concomitant right of one to assist in his or her own defense, and the guarantee of a fair trial.229

In resolving the issue of whether inmates have the right to refuse psychotropic drugs, the courts have also been forced to address a myriad of other issues ranging from impairment of defense to bodily integrity.230 Though the Court has addressed these issues in a number of other contexts, both Harper231 and Riggins232 provided rather unique opportunities to break new ground regarding the degree to which the state can infringe upon or diminish an inmate's rights in these areas. This section will briefly explore these areas, given the pivotal role they continue to play in determining the limits of state power or control over inmate populations.

1. Freedom of thought and trial rights

The side effects of psychotropic drugs are well known in the psychiatric and medical communities.233 Among other things, many of these drugs have been found to have sedative properties that may potentially interfere with the cognitive and intellectual abilities of those who receive injections.234 The impact of such side effects on inmates and pre-trial defendants inside and outside of the courtroom has generated a number of questions for courts as plaintiffs have begun to raise a number of serious constitutional questions regarding their usage.235 For instance, legal

229. Id.
230. People v. Straub, 292 Ill. App. 3d. 193, 198 (1997) ("A defendant who is receiving psychotropic drugs or other medications under medical direction is entitled to a hearing on the issue of his fitness while under medication."); People v. Nitz, 1996 WL 33422046, *6-7 (Ill. 1996) ("During the collateral attack on his convictions and sentence, Nitz alleged that because the State did not inform his trial counsel that he was being administered psychotropic medication throughout the course of his trial, he was deprived of his constitutional due process right to a fitness hearing.").
233. See Martinez et al., supra note 27.
234. See id.
235. Cf. People v. Kinkead, 695 N.E.2d 1255, 1269 (Ill. 1998) (discussing concern that the defendant's ingestion of antipsychotic drugs during the plea and sentencing proceedings potentially influenced his decision-making abilities); People v. McKay, 668 N.E.2d 580, 585 (Ill. App. 1996); Girouard v. O'Brien, 1988 U.S. Dist. Lexis 4342, at *10 (Kan. 1988) ("Antipsychotic drugs have the capacity to severely and even permanently affect an individual's ability to think and communicate... first amendment considerations are also at stake since it protects the communication of ideas, which itself implies protection of the capacity to produce.").
challenges have alleged that the forcible administration of psychotropic drugs inhibits or interferes with the right to a fair trial and the ability to meaningfully engage in plea bargaining.236 Recently, an appellate court in Illinois reversed the conviction of a defendant based on the premise that the state could not show with any medical certainty that he could understand and participate in his own defense.237 Recognizing that these drugs may on occasion affect defendants' mental condition and alertness, this court concluded the state must produce evidence, beyond a mere bare assertion, that the defendant was not impaired as a result of the medication.238

Importantly, Justice Kennedy has acknowledged that significant trial rights may be jeopardized when psychotropic drugs alter a defendant's demeanor and interfere with his ability to assist in his own defense.239 His concern primarily resided with the lingering negative impression that would be left in the minds of the judge or jurors were they to actually observe any "unusual" or "bizarre" expressions and behaviors by the defendant.240 Moreover, Justice Kennedy was concerned that the state may attempt to subvert the trial by suggesting that the "odd" behavior of the defendant is an indicator of guilt.241 Courts have regularly constructed prophylactic barriers to ensure that defendants are not impaired or unfairly burdened in situations where prosecutors attempt to infer guilt from their silence or refusal to take the stand.242 Where prosecutors suggest that juries should draw a negative inference from the failure to exercise a constitutional right, courts have held that an error of constitutional proportions has occurred.243

At least one court has held it is impermissible for prosecutors to link guilt to the demeanor of a defendant who had been given psychotropic drugs against his will prior to and during trial.244 Among other things, the

238. Id. at 805.
239. Riggins v. Nevada, 504 U.S. 127, 142 (1992) (Kennedy, J., concurring) (expressing concern that certain behavioral and physical attributes induced by psychotropic drugs could exert a prejudicial effect on both the judge and jury. More specifically, Justice Kennedy believed that defendants who are given these drugs would likely display characteristics or mannerisms that may influence how judges and juries would respond to him. In this regard, forcing defendants to take these drugs may be no different from ordering them to be shackled or muzzled.); see also In Re Davis, 101 P.3d 1, 29 (Wash. 2004).
240. Riggins, 504 U.S. at 142.
241. Id. at 143.
243. See id. at 1305; see also Anderson v. Nelson, 390 U.S. 523, 524 (1968); Davis v. Quarterman, 237 F. App'x 903, 907 (Tex. 2007).
appellate court held that psychotropic drugs cannot be administered to non-psychotic individuals. More importantly, the court found that these drugs may induce a demeanor and other characteristics that can easily be misinterpreted by a jury. Finally, the court found it was inappropriate for the state to tie the defendant’s demeanor to claims of “future dangerousness” or guilt.247

Notwithstanding this fact, petitioners seeking legal redress have achieved mixed success in the courts. There is no presumption that inmates and other pre-trial defendants are competent merely because they are taking psychotropic drugs. However, where such drugs have been administered and are found to alter defendants during critical phases, such as plea bargaining or the trial itself, a judicial remedy must be provided. Perhaps just as pertinent, the Supreme Court has held that inmates may be involuntarily medicated only where they are found to be a danger to themselves or others.250

Given this holding, the legitimacy of forcibly administering psychotropic drugs to pre-trial defendants is highly questionable unless a determination has been made that they would be a danger to themselves or others during the trial. This view is supported by In re Pray251 and State v. Maryott,252 yet these holdings have largely been ignored outside of a very small number of judicial venues.253

Significant trial rights are potentially compromised when pre-trial defendants and inmates are forced to take psychotropic drugs. Even though the Court has held that trial procedures cannot be put into place that are disproportionate to the purpose they are meant to serve,254 many courts allow the forcible administration of psychotropic drugs to continue unimpeded.

Though some may argue the use of these drugs in the trial context is precautionary, the fact remains their use may not be necessary to achieve

245. Id. at *53-56. The appellate court focused on prior Supreme Court rulings which held that psychotropic drugs can only be administered when “medically appropriate.” Id. at *56. Though the term “medically appropriate” may be subject to interpretation, courts have generally said that an individual must be a danger to himself or others before psychotropic drugs can be forcibly administered. See Washington v. Harper, 494 U.S. 210, 227 (1990).

246. Willis, at *68-69.

247. Id. at *105-06.


252. 492 P.2d 239 (Wash. 1971).


the state's goal of assuring defendants are tried in a timely and fair manner.\textsuperscript{255}

2. Bodily integrity

Since the advent of the so-called "therapeutic orgy,"\textsuperscript{256} many scholars have consistently argued that the forcible administration of psychotropic drugs is an invasion of one's bodily integrity.\textsuperscript{257} The legal rationale underlying bodily integrity extends beyond Washington \textit{v.} Harper where the Court held that inmates retain a significant liberty interest in remaining free of unwanted psychotropic drugs.\textsuperscript{258} Such a presumption can only be overcome when the state demonstrates that administering the drugs is consistent with the medical interests of the inmate and the security needs of the institution.\textsuperscript{259} One of the major premises from which bodily integrity is derived is the right to be secure in one's own body.\textsuperscript{260} The forcible administration of psychotropic drugs weakens this right because inmates and pre-trial detainees may suffer from a number of side effects attributable to the use of these drugs.\textsuperscript{261}

In addition to non-neurologic effects, such as vomiting and urinary retention, these drugs are also known to produce blindness and increase blood toxicity.\textsuperscript{262} Among the more severe neurologic side effects, researchers have found that the drugs may cause tardive dyskinesia and neuroleptic malignant syndrome.\textsuperscript{263} Though these conditions may be rare, it is reasonable to presume that inmates and pre-trial detainees would want to limit their exposure to these debilitating and permanent conditions.\textsuperscript{264}

\begin{itemize}
  \item \textsuperscript{255} See Ake \textit{v.} Oklahoma, 470 U.S. 68 (1985).
  \item \textsuperscript{256} Robert Plotkin, \textit{Limiting the Therapeutic Orgy: Mental Patient's Right to Refuse Treatment}, 72 NW. U. L. REV. 461 (1977-78).
  \item \textsuperscript{257} \textit{Id}.
  \item \textsuperscript{258} 494 U.S. 210 (1990).
  \item \textsuperscript{259} \textit{Id} at 225-26.
  \item \textsuperscript{260} Vitek \textit{v.} Jones, 445 U.S. 480, 495 (1980).
  \item \textsuperscript{261} See William Ziegelmueller, \textit{Due Process on Drugs: The Implications of Forcibly Medicating Pre-Trial Detainees with Antipsychotic Drugs}, 83 J. CRIM. L. & CRIMINOLOGY 836 (1993).
  \item \textsuperscript{262} \textit{Id} at 839.
  \item \textsuperscript{263} Martinez et al., supra note 27; Steven Garlow, David Purselle & Barbara D'Ono, \textit{Psychiatric Emergencies that Usually Require Pharmacological Intervention}, in ESSENTIALS OF CLINICAL PSYCHOPHARMACOLOGY 707 (Alan Schatzberg & Charles Nemeroff, eds. 2006); Dilip V. Jeste et al., \textit{Incidence of Tardive Dyskinesia in Early Stages of Low Dose Treatment with Typical Neuroleptics in Older Patients}, 156 AM. J. PSYCHIATRY 309, 309-11 (1999); Ramzy Yassa et al., \textit{Factors in the Development of Severe Forms of Tardive Dyskinesia}, 147 AM. J. PSYCH. 1156, 1156-63 (1990).
  \item \textsuperscript{264} See John Wilkaitis, Teresa Mulvhill & Henry Nsrrallah, \textit{Classic Antipsychotic
The reasonableness of any policy, which would require inmates, pre-trial detainees, or patients to unknowingly subject themselves to the debilitating effects of these drugs, surely implicates the degree to which the state’s interests outweigh the harms that are caused by forcing inmates and pre-trial detainees to ingest these drugs.\textsuperscript{265} In \textit{Riggins}, the Court held that the forcible injection of these drugs must be in the inmate’s medical interests.\textsuperscript{266} At various times, however, the Court has also held that any medical treatment that is contrary to an individual’s wishes interferes with his right to bodily integrity.\textsuperscript{267} To this end, several federal courts have held that independent corroborating evidence is appropriate where the state seeks to medicate an individual against his will.\textsuperscript{268}

In light of these developments, many courts apparently have come to recognize the dangers of allowing psychotropic drugs to be administered with impunity. Scholars have attempted to tease out whether the therapeutic benefits associated with antipsychotic drugs, arguably the crux of the Court’s decisions in both \textit{Harper}\textsuperscript{269} and \textit{Riggins},\textsuperscript{270} outweigh their costs in terms of their side effects and their interference with one’s liberty interests.\textsuperscript{271} Importantly, the federal courts have consistently maintained that to preserve respect for the autonomy interests of individuals, they must be allowed to make decisions for themselves, even foolish ones.\textsuperscript{272} Also, various courts have made it clear that both the benefits and burdens of medical procedures, and medication by extension, must be evaluated in

\textit{Medications, in \textit{Essentials of Clinical Psychopharmacology} 211, 223-24} (Alan Schatzburg & Charles Nemeroff, eds. 2006). Researchers have noted that though the risk of actually acquiring neuroleptic malignant syndrome (NMS) is small, about .02% to 2%, its mortality rate approaches 30%. \textit{Id.} at 224. Moreover, its onset can be detected in approximately 80% of cases within two weeks of receiving psychotropic drugs. \textit{Id.}


\textsuperscript{266} 504 U.S. 127, 134-35 (1992).


\textsuperscript{269} 494 U.S. 210 (1990).

\textsuperscript{270} 504 U.S. 127 (1992).


light of one's right to control his medical treatment. Thus, it would seem that the underlying premise of bodily integrity has remained intact and courts should ensure that this right is respected, notwithstanding the professed needs of the state.

IV. THE PROMISE OF SELL

When read together, the Harper and Riggins decisions suggest that there was a transformation in the manner that Justice Kennedy approached the issue of inmates and the forcible administration of psychotropic drugs. Where Justice Kennedy’s opinions once focused on the procedural intricacies and the penal interests of the state, he later adopted an approach that seemed to reflect a concern with the potential misuse of psychotropic drugs and their effect on detainees and inmates. While the precise events that led to this change are unknown, it is clear that Justice Kennedy found the use of psychotropic drugs to be problematic in light of the emerging scientific knowledge about their short- and long-term side effects.

From 1992 to 2000, courts at both the state and federal levels, and important actors within the criminal justice system, continued to struggle with this issue. Just as courts from this early period struggled with balancing the penological needs of prisons with the liberty interests of prisoners, these issues continued to bedevil judges throughout the 1990s. For example, in Singletary v. State, the Supreme Court of South Carolina held that psychotropic drugs could be administered to an inmate only if he posed a danger to himself or others. Taking its direction from Justice Kennedy, the court also ruled that inmates have a right to be free from

unwarranted medical intrusions into their minds, thoughts, and bodies. The court also relied on the Hippocratic oath to convincingly argue that the unusualness of the environment in which medical professionals operate may effectively prevent them from administering psychotropic drugs that manifest themselves in the form of "psychic side-effects." In subsequent cases, courts continued to rely on the "dangerousness" prong of the Harper decision in their determinations of whether psychotropic drugs could be forcibly administered to inmates. In United States v. McAllister, for example, the District Court held that a finding of dangerousness is a prerequisite to administering these drugs to inmates. More specifically, the court held that a finding of dangerousness may balance and accommodate an inmate's liberty concerns with the concerns of the penal institution. Whenever this burden is met, it is incumbent upon the court to halt further injections of these drugs.

The Supreme Court's decision in Sell v. United States arguably provided the final word on whether psychotropic drugs could be forcibly administered to inmates. Not unlike previous cases, Sell presented the Court with an opportunity to break new ground or retreat into the formalism of its prior precedent. Unmistakably, the Court chose the latter course. Sell, a practicing dentist, was prosecuted for fraud and money laundering. Given his long history of mental illness, few were surprised when his condition began to deteriorate. Sell was ordered by a federal magistrate to be hospitalized to receive treatment, and the medical staff recommended a short time later that he receive psychotropic drugs. After Sell repeatedly refused to take these drugs, the medical staff sought an order to administer these drugs over his objections. Both the District Court and the Court of Appeals affirmed the order of the Magistrate resulting in the appeal before the Supreme Court.
In delivering the opinion of the Court, Justice Breyer held that four conditions must be met by the state before it could proceed with its plans to forcibly administer psychotropic drugs. First, an important government interest must be implicated. The desire to bring a defendant to trial in a timely and efficient manner satisfies this interest. Second, involuntary medication must further the state's interest in bringing a defendant to trial. However, this interest will be substantially diminished if the drugs interfere with the defendant's right to a fair trial. Third, alternative and less-intrusive measures must be beyond the reach of the state. Fourth, the proposed usage of the drugs must be medically appropriate, meaning that dosage levels and side effects can be controlled.

Importantly, the Court's holding did not repudiate Justice Kennedy's opinions in Harper and Riggins. Rather, this decision seemed to reinforce them to the extent that the side effects of these drugs on inmates must be balanced against the state's interests. A significant difference is that Justice Breyer, rather than Justice Kennedy, recognized that it is appropriate for courts to focus on the question of dangerousness as opposed to competence. Making determinations of dangerousness should be a first-order concern given that it implicates the appropriateness of administering the drugs themselves.

V. CONCLUSION

The issue of administering psychotropic drugs to inmates, while controversial, has received little attention in the literature. The most salient issues raised by these cases have focused the courts' attention on bodily integrity, the penalogical interests of the state, and dangerousness. For the most part, these cases endorse the principle that the state's interest in medicating inmates carries as much weight as the inmate's desire to be free from these drugs. At the same time, courts have wrestled with

289. Id. at 180.
290. Id.
291. Id.
292. Id. at 181.
293. Id.
294. Id.
295. Id. at 181-82.
297. Sell, 539 U.S. at 182.
298. Id. at 183.
300. Id.
whether the deprivations suffered by inmates are separate and distinct from the need of prisons to be secure and orderly. Despite this fact, courts at both the state and federal levels have tended to question the legitimacy of the decision to involuntarily medicate inmates where there is no clear connection between the use of psychotropic drugs and the needs of penal institutions, or where dangerousness is not at issue. Early cases such as *Rennie* and *Rogers* showed that one's right to bodily integrity cannot be diminished unless the state showed that there was an emergency or danger. These principles provided the basis for the Supreme Court's decision in *Washington v. Harper*, where Justice Kennedy reasoned that the exigencies of the prison environment require deference to the decision-making ability of penal officials and other professionals who confront and address the special needs of this population.

It is unlikely that the courts will ever say that psychotropic medications cannot be administered at any time. However, Justice Kennedy's concerns about "deference to professionals" should be given more attention. That is, the courts should not rely solely on the opinions of doctors or penologists who have a vested interest in administering psychotropic medications to those individuals who are deemed difficult to treat or difficult to handle. This is not to suggest that the motives of the state are always questionable. However, the courts should maintain some degree of oversight when decisions are made that intrude upon the most personal of all provinces—the mind.

There may be concerns about the state's motives in its attempts to render inmates and detainees competent to stand trial. It could be argued that these same concerns persist behind the walls of prisons since many states persist in their efforts to alter the mental processes of inmates to achieve a degree of compliance or passivity for the purpose of creating a "safe" and "orderly" environment. Despite the Court's final word, continued oversight and engagement is needed so that inmates' identities and thoughts are not taken away in furtherance of questionable state goals. Justice Kennedy seems to have belatedly reached this conclusion.

301. Id.