

Clinical & Legal Visions of Involuntary Medication to Restore Trial Competence

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Before I speak, I have
something important to say.

- Groucho Marx

I. Brief Background on Involuntary Treatment & Dangerousness

CT History as Illustration of Previous Theory of Invol Rx

- Prior to 1993, CGS said:
 - “Voluntary patients may receive medication or treatment, but shall not be forced to accept unwanted medication or treatment.”
 - **“Involuntary patients may receive medication and treatment without their consent,** but no medical or surgical procedures may be performed without the patient’s written informed consent.”
- CGS 17a-543

Mass – Rogers decisions 1982/83

- Boston State Hospital patients filed suit 1975
 - Forced medication violated constitutional rights
 - State maintained all committed patients were *per se* incompetent to make treatment decisions
 - Trial court and 1st Circuit affirmed that mental illness did not make patients incompetent to make Rx decisions *per se* & required balancing of state interest in avoiding violence
 - USSC remanded back to 1st Circuit to determine rights of parties under Mass law
 - Mass Supreme Judicial affirmed that involuntarily committed patients may be competent to make tx decisions unless determined to be incompetent by judge. If incompetent, substituted judgment required.

**Socio-Legal Context of Evolving
Reliance on Dangerousness
as the Threshold
for Involuntary Treatment**

Social Context

- Deinstitutionalization
 - 1960's forward
- Increase in voluntary commitment
 - 1971 first time majority of patients voluntary in U.S.
- Pursuit of libertarian ideals
 - police power as highest possible rationale for commitment

Legal Decisions

- Baxstrom v. Herold, 1966:
dangerousness required for psychiatric commitment of inmates (USSC)
- Lake v. Cameron, 1966: if person dangerous only to self, deprivation of liberty must be limited (D.C. Circuit Court of Appeals)

Legal Decisions (cont'd)

- *Hawks v. Lazaro*, 1974: upheld dangerousness as criterion; struck down *parens patriae* (W.VA SC)
- *O'Connor* 1975: cannot confine non-dangerous mentally ill persons capable of living in community (USSC)

Paradigm extended to outpatients

- Tarasoff, 1976: when dangerousness determined, duty to protect victim arises (CA SC)
- Lipari, 1980: therapist has duty to warn/detain when he should have known pt's dangerousness (fed District Court)
- Peck, 1985: Outpatient therapist responsible to warn/protect for danger to property (VT SC)

Paradigm extended further

- In *Jurek v Texas* (1976), *Estelle v. Smith* (1980) and *Barefoot v. Estelle* (1983) USSC supported use of psychiatric prediction of dangerousness in capital sentencing proceedings
- In *Jones v. U.S.* (1983) USSC ruled that finding of insanity - even for nonviolent property crime - was sufficient evidence of dangerousness to permit indefinite commitment of acquittee

A New National Standard

- Old notions of invol tx for invol pts disappeared in late 80's/ early 90's
- Differential assessment of competencies and retention of rights not adjudicated became national standard
- For example, in CT in 1993:
 - Created requirement for determination of specific decision-making competence re Rx
 - Created 1) internal panel, or 2) conservator with med authority, or 3) probate court decision as routes to involuntary medication
 - **CSTR specifically excepted from new statute**

II. Analysis of U.S. Supreme Court Cases

Washington v. Harper 1990

- USSC recognized prisoner's liberty interest in avoiding involuntary antipsychotic medication & state's interest in providing appropriate medical treatment to reduce danger due to mental illness
- 6-3 decision on essential elements
- J Kennedy: "the effect of these and similar drugs is to alter the chemical balance in the brain, the desired result being that the medication will assist the patient in organizing his or her thought processes and regaining a rational state of mind."

Harper (#2)

- Disagreed that prisoner's refusal may be overridden only if prisoner incompetent and a factfinder makes a substituted judgment
- Affirmed prison policy as meeting substantive and procedural due process requirements; inmate must:
 - have mental illness
 - “Gravely disabled” or “likelihood of serious harm” to self, others, property
- Equated this to attention to medical interests of the prisoner

Harper (#3)

■ Grave disability:

- danger of serious physical harm resulting from a failure to provide for essential human needs, *or*
- Severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over actions and not receiving care that is essential

Harper (#4)

- Likelihood of serious harm is substantial risk of physical harm, evidenced by
 - threats or attempts to commit suicide or inflict physical harm on self, *or*
 - Past behavior of harm to others or property

Harper (#5)

■ J. Kennedy:

- “The drugs may be administered for no purpose other than treatment...”
- Risks associated with drugs are medical ones, best assessed by medical professionals

Harper (#6)

■ J. Stevens dissent:

- “The liberty of citizens to resist the administration of mind altering drugs arises from our Nation’s most basic values.”
- Quoted PDR lists of side effects, emphasizing Tardive Dyskinesia & Neuroleptic Malignant Syndrome (Mr. Harper rec’d only typical antipsychotics)
- Equated intrusiveness of antipsychotics to ECT & psychosurgery
- Denied majority’s claim that Washington policy required consideration of inmate’s medical interest

Harper (#7)

- American Psychiatric Association amicus:
 - Antipsychotic medications effective tx
 - Side effects are real, but most are manageable and worst occur in small % cases: high benefit / risk ratio
 - Alternative of judicial hearing for each case of invol Rx unworkable and would not lead to conclusions consistent with best medical interests of individual
 - Principle of best medical interests supports both state and individual's interests; best accomplished by professional judgment, as in Washington policy

Riggins v. Nevada 1992

- Mr. Riggins awaiting trial on murder/robbery, began hallucinating, given Thioridazine (Mellaril)
- Later refused, was found competent & his motion to cease Mellaril during trial was denied
- Insanity defense failed; found guilty and sentenced to death
- Nevada SC affirmed; US SC reversed – no finding that Rx was necessary to government interest

Riggins (#2)

- State **would** have satisfied due process if:
 - Tx medically appropriate, *and*
 - Essential for safety of Mr. Riggins / others
- State **might** have been able to justify involuntary Rx of defendant to restore CST, if:
 - Tx medically appropriate, *and*
 - State could not obtain adjudication w/ less intrusive means

Riggins (#3)

■ J. Kennedy concurring opinion:

“I file this separate opinion, however, to express my view that the Due Process Clause prohibits **prosecuting officials from administering involuntary doses of antipsychotic medicines** for purposes of rendering the accused competent for trial absent an extraordinary showing, and to express doubt that the showing can be made, given our present understanding of the properties of these drugs.”

Riggins (#4) J. Kennedy (cont'd):

- “When the State commands medication during the pretrial and trial phases of the case **for the avowed purpose of changing the defendant’s behavior**, the concerns are much the same as if it were alleged that the prosecution had manipulated material evidence.”
- In Harper, invol Rx inquiry is “objective and manageable,” in contrast to Riggins (next)

Riggins (#5) J. Kennedy:

- In Riggins, “the purpose of the medication is not merely to treat a person with grave psychiatric disorders and enable that person to function and behave in a way not dangerous to himself or others, but rather to render the person competent to stand trial.”
- “The avowed purpose of the medication is not functional competence, but competence to stand trial.”
- Medication can prejudice defendant by
 - Altering demeanor
 - Rendering him unable / unwilling to assist counsel

Riggins (#6) J. Kennedy:

- “The 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.**”
- “In my view medication of the type here prescribed may be **for the very purpose of imposing constraints on the defendant’s own will,** and for that reason its legitimacy is put in grave doubt.”

Riggins (#7) J. Kennedy:

“If the State cannot render the defendant competent without involuntary medication, then it must resort to civil commitment, if appropriate, unless the defendant becomes competent through other means. If the defendant cannot be tried without his behavior and demeanor being affected in this substantial way by involuntary treatment, in my view the Constitution requires that society bear this cost in order to preserve the integrity of the trial process.”

Riggins (#8) - Discussion of J. Kennedy

- What cost?
 - Of indefinite civil commitment?
 - Implicating hospital as agent of social control?
- What happened to J. Kennedy's praise of the medical profession's adherence to ethical principles in Harper?
- How / why does J. Kennedy equate the treating professionals with the State?
- Why no mention of atty responsibility to raise competency issue during trial, or of medical professional judgment during treatment?

Riggins (#9)

Am Psychiatric Assoc Amicus Brief

- Antipsychotic Rx highly effective; some side effects (as in Harper)
- Such Rx powerful tool for restoring, rather than impairing, competence
- Not “synthetic sanity”
- Rx to restore competence must be in pt’s medical interest and effects properly monitored throughout criminal proceedings

Riggins (#10)

APA Amicus Brief cont'd

- Liberty interests and potential side effects require state justification for invol Rx **at prescribed dose**
 - May cause restlessness, flatness, sedation, other effects on demeanor
 - May appear bored, cold, unfeeling, unresponsive
 - This is an evidentiary handicap for defense: “When the State forces the defendant to start with one strike against him for no legitimate reason, he is deprived of his constitutional right to demand that the government prove its case beyond a reasonable doubt, without assistance from the defendant.”

Riggins (#11)

APA Amicus Brief cont'd

- Defendant has right not to be rendered incompetent to stand trial
 - “Abuse of psychotropic drugs...could conceivably impair that right by interfering with a defendant’s ability to understand the proceedings and to assist counsel.”

Riggins (#12)

APA Amicus Brief cont'd

- Prisoner's medical interests and legitimate needs of his institutional confinement can be easily reconciled by good medical practice.
- Balance of state interest in trying defendant vs. individual liberty interest must be determined by court
 - But court should recognize that “treatment and institutional needs will often coincide with the need to restore or maintain competence.”

Riggins (#12) Analysis

- Court & APA ignored the clinical realities of how competency restoration is accomplished
- Both raised specter of misuse of Rx, raising fear of State interests in disregard of medical interests
- May be partly due to strange circumstances of the involuntary Rx in Mr. Riggins' situation

Sell v. U.S. 2003

- Dr. Sell was a practicing dentist with long h/o psychotic illness
- May 1997 fed gov't charged him with fraud
- Early 1998 in court: screaming, shouting, insulting, racial slurs, spitting at judge -> bail revocation
- April 1998 indictment added for attempted murder of FBI agent

Sell (#2)

- Early 1999 Dr. Sell asked for competence hearing, found **incompetent**, sent to federal medical center
- **Refused recommended Rx; staff sought permission to medicate against his will**
- June 1999 – Aug 2000 series of administrative reviews and danger determinations
- Aug 2000 fed **magistrate agrees he is dangerous and orders invol Rx**, but stays order
- April 2001 **District Court finds Dr. Sell not presently dangerous**, magistrate clearly wrong, but **ordered Rx as medically appropriate & only way to adjudicate case**

Sell (#3)

- March 2002 8th Cir. Court of Appeals affirms Dr. Sell's non-dangerous condition & the order for Rx to restore CST
 - Rx was medically appropriate & not likely to interfere with trial participation
- USSC grants cert to review 8th Cir. decision to order involuntary meds **solely to restore CST**

USSC holding in *Sell* (June 16, 2003)

- Harper and Riggins provide framework for the necessity of 4 court findings:
 1. **Important** governmental interests are at stake
 2. Invol Rx will **significantly further** those interests and side effects will not interfere with ability to assist counsel
 3. Invol rx is **necessary** to further gov't interests
 4. Rx is **medically appropriate** (in patient's best medical interest)

USSC dicta in Sell

- Strong reasons to consider forced Rx for other purposes, such as controlling danger or risk to individual's health, BEFORE turning to CST question
- If Rx can be authorized on alternate grounds, need to do so for CST purposes disappears
- If court asked to order invol Rx for CST restoration, court should ordinarily ask if gov't has already sought Rx on the Harper-like grounds, and if not, why not

USSC dicta in Sell (#2)

- Reiterates J Kennedy's concurring opinion in *Riggins* that inquiry as to whether Rx to treat dangerousness is "usually more 'objective and manageable' than the inquiry into whether medication is permissible to render a defendant competent"
 - Easier for medical experts to balance risk of side effects against reduction of danger than against trial fairness and competence

USSC dicta in Sell (#3)

- Every state addresses these issues as civil matters, on “these alternate, *Harper-type*” grounds
- If court authorizes Rx on alternate grounds, issue of authorization for restoration of competence likely disappears
- Dr. Sell’s refusal of Rx might result in further lengthy confinement, which reduces likelihood of future crimes and thus “moderates” importance of gov’t interest in prosecuting him

USSC dicta in Sell (#4)

- Court asks 2 questions:
 - “Why is it medically appropriate forcibly to administer antipsychotic drugs to an individual who (1) is *not* dangerous *and* (2) is competent to make up his own mind about treatment?”
 - “Can brining such an individual to trial *alone* justify in whole (or at least in significant part) administration of a drug that may have adverse side effects, including side effects that may to some extent impair a defense at trial?”

Am Psychiatric Assoc Amicus in *Sell*

- Rx must be
 - Medically appropriate under normal balancing of risks and benefits
 - Reasonably capable of achieving restoration
 - Reasonably necessary to achieve restoration
- Significant advances in psychopharmacology (atypical antipsychotics) since *Harper & Riggins*

APA Amicus in Sell (#2)

- Appropriate Rx typically enhances rather than impairs a defendant's ability to participate effectively at trial
- Any concerns about sedation or other adverse effects are properly considered at later stage, after competence restored
 - “the mere possibility of such effects should not stand in the way of restoring competence”
 - Side effects can be monitored and controlled

APA Amicus in Sell (#3)

- There is evidence for Rx success in delusional disorder
- “The Court should not ignore the real costs of leaving a defendant untreated when he needs such medically appropriate treatment.”
 - Languishing, suffering, impairment of function
 - Medical risks of delayed treatment
 - Effects on families & institutions* of untreated psychosis
 - *Threatens therapeutic milieu & recruitment of high quality staff; staff become jailers/custodians

Timing of Cases & Atypicals

■ Cases:

- Harper 1990
- Riggins 1992

■ Atypicals:

- Clozapine (Clozaril) 1990
- Risperidone (Risperdal) 1994
- Olanzapine (Zyprexa) 1996
- Quetiapine (Seroquel) 1998
- Ziprasidone (Geodon) 2000
- Aripiprazole (Abilify) 2002
- Sell 2003
- Evans 2005

Analysis

■ USSC “clinical” errors:

- Civil handling of invol Rx does not necessarily use Harper-like justifications
 - Substituted judgment does not require danger
 - Deterioration of function, effect on future Rx efficacy, continued confinement, alleviation of pain/suffering, personal preference may all be determinative
- Poor understanding (or acknowledgement) of dynamic nature of CSTR processes
 - Rx cannot simultaneously bring defendant to trial & impair his/her defense
- Seems to legitimate long-term warehousing of pt receiving no definitive treatment

Analysis (#2)

- APA Brief seems sensitized to *Riggins* brief:
 - Even typical antipsychotics were tx of choice
 - Possibility of s/e's is found in all of medical care; does not defeat State interest in restoring competence; can be monitored & managed (point made repeatedly)
 - Vatican-like effort to demonstrate continuity of opinion
 - Long discussion of medical reasons for tx
 - Still fails to describe CSTR processes in helpful way

Analysis (#3)

APA Briefs in Riggins vs. Sell

■ Riggins

- “Demeanor evidence might be particularly influential in cases where an insanity defense is at issue.”
- “By administering medication, the State may be creating a prejudicial negative demeanor in the defendant – making him look nervous and restless, for example, or so calm or sedated as to appear bored, cold, unfeeling, and unresponsive.”

■ Sell

- “The evidentiary significance of demeanor in legitimately establishing the defendant’s insanity at the time of a crime is not particularly strong.”

A troubling post *Sell* case

- *U.S. v. Evans* (4th Cir. 2005) VA case
 - Elderly man threatened fed magistrate
 - Importance of gov't interest can be determined by potential sentence (8 yrs is important enough)
 - Likelihood of restoration & unlikeness of side effects are individual, not categorical, determinations

Evans (#2)

- To satisfy medical appropriateness and best medical interest, must provide
 - Particular Rx and dose range
 - Specific relation between proposed Rx plan and defendant's particular medical condition
 - Estimate of how long plan will take to restore CST
 - What criteria will be used in deciding to d/c Rx?
 - Plan's probable benefits and side effects for defendant's specific medical condition
 - How will tx plan deal with probable side effects?
 - Why do benefits outweigh cost of side effects?
 - May provide multiple plans, but specify order in which they will be attempted

Evans (#3)

“To approve of a treatment plan without knowing the proposed medication and dose range would **give prison medical staff carte blanche to experiment with** what might even be **dangerous drugs or dangerously high dosages** of otherwise safe drugs and would not give defense counsel and experts a meaningful ability to challenge the propriety of the proposed treatment.”

Evans (#4) Analysis

- *Evans* court continues *Sell* court's poor understanding and misstating of the process of treating defendants found incompetent to stand trial.
- Both seem to ignore medical ethics and standard of care issues, and regard the treatment staff as mere extensions of the government's prosecutorial function.
- Court intrusion into medical judgment problematic and unwarranted

III. Problems for Clinicians

Reliance on Harper-like Grounds

- Link between mental illness & violence risk is complex and conflicting
 - Substance abuse is a consistently reported risk factor for violence, alone and in combination with mental disorders
 - Sociodemographic factors contribute significantly to violence - more than mental health factors
 - Relationship between psychosis (and other sx of mental illness), diagnosis and violence not conclusive, based on conflicting research findings
 - see Norko & Baranoski 2008

Reliance on Harper-like Grounds (#2)

- Conflicts re clinical vs. actuarial assessment of violence risk
 - Historical data may best inform long-term and community risk (in treated populations)
 - Clinical data may best inform inpatient risk in acutely ill persons
 - see McNeil et al 2003
 - Predicting violence still difficult
 - See Gerbasi & Scott 2007

Reliance on Harper-like Grounds (#3)

- What data will be necessary/ effective in contested court hearings?
 - What level of danger justifies invol Rx before trial?
- Civil administration of Rx requires danger (sometimes imminent) and/or incompetence for informed consent +/- necessity
 - Harper requires only danger + medical appropriateness
 - Is danger in prison like danger in forensic hosp?
 - see Gerbasi & Scott 2004

Treatment of Dangerousness

- Aggression cuts across diagnostic categories
- Rx categories used in tx of aggression:
 - Antipsychotics (typical & atypical)
 - Antidepressants
 - Anxiolytics
 - Mood stabilizers
 - Anticonvulsants
- see Glancy & Knott 2002-2003

Glancy & Knott Algorithm

- Major mental illness:
 - Psychosis
 - Atypical, then typical antipsychotics
 - Adjunctive mood-stabilizers, beta blockers, buspirone
 - Depressive disorders
 - SRIs
 - Adjunctive buspirone
 - Beta-blockers
 - Bipolar/manic
 - Mood stabilizers
 - Adjunctive atypical antipsychotics

Glancy & Knott Algorithm (#2)

- No functional MI (MR, Brain injury, dementia, abnl EEG):
 - Anticonvulsants
 - Li
 - Beta blockers
 - Buspirone for anxiety related aggression

Glancy & Knott Algorithm (#3)

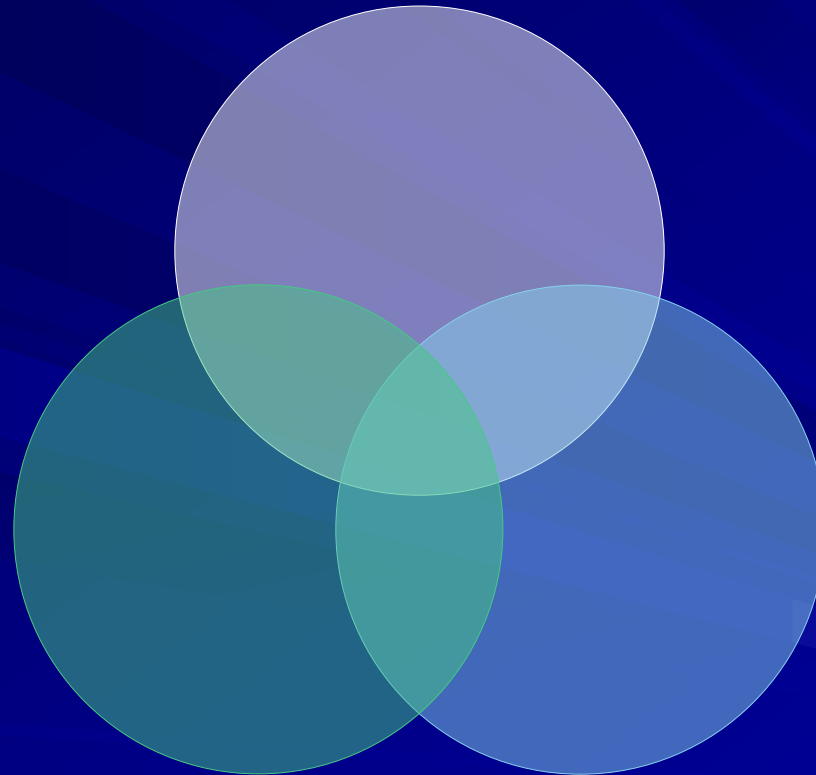
- No underlying major psychiatric conditions:
 - Psychosocial interventions
 - SRIs
 - Li
 - Beta-blockers
 - Trazodone
 - Benzodiazepines for short-term substance withdrawal

Do Dangerousness & Incompetence Overlap Sufficiently to Form Basis for Treating Incompetent Defendant à la Sell?

- Most cases of incompetence related to psychosis & MR, with fewer number related to mood disorders
 - see Mossman et al. 2007 (AAPL Practice Guidelines)
- Well below average rates of competence restoration for chronically psychotic defendants w/ histories of lengthy inpt. hospitalization & irremediable cognitive disorders (like MR)
 - see Mossman 2007

Overlap

Psychotic



Dangerous

Incompetent

Analysis: Tx of Dangerousness

- No such thing as a specific tx of dangerousness
- Issue always returns to the medical appropriateness of the tx **for the individual**
- Concept of dangerousness does not assist many of these considerations
 - *Harper* not a good model for the alternate methods of *Sell dicta*

IV. CT's Response to *Sell* Holding & Dicta

CT SC decision: State v. Garcia 1995

- Drew on *Riggins* and *Washington v Harper*
- To order invol Rx to restore CST, must show **5 factors by clear & convincing evidence**
 1. Invol rx will render defendant competent
 2. Adjudication not possible w/ less intrusive means
 3. Proposed tx plan narrowly tailored to minimize intrusion on defendant's liberty and privacy interests
 4. Proposed Rx will not cause unreasonable risk to defendant's health
 5. Seriousness of alleged crime such that state's interest overrides defendant's interests

CT Garcia decision (#2)

- Also required appointment of health care guardian to represent “actual best medical interests” of defendant, recognizing divergence from legal interests or defendant’s stated preferences
 - IF defendant is incapable of informed consent

CGS amended

- In 1998, legislature incorporated the “Garcia rules” of the CT SC into the 54-56d statute in subsection (k)
 - Called for licensed health care practitioner to advise court
 - In 2001, advisor renamed “Health Care Guardian” and granted protections for that role against liability

54-56d(k)

- If defendant “unwilling or unable to provide consent” to psychiatric medication, court will:
 - Hold hearing to determine whether by C&CE each of the 5 factors are present
 - Appoint HCG to advise court via report/testimony if unable to provide consent

Sell factors mapped onto Garcia

SELL

1. Important gov't interests at stake

2a. Invol Rx will signif further those interests

2b. Side effects will not interfere with ability to assist counsel

GARCIA

5. Seriousness of alleged crime such that state's interest overrides defendant's interests

1. Invol Rx will render defendant competent

3. Proposed tx plan narrowly tailored to minimize intrusion on def's liberty & privacy interests...[but no specific statement re side effects at trial]

Sell onto Garcia (#2)

Sell	Garcia
3. Invol Rx necessary to further gov't interests	2. Adjudication not possible w/ less intrusive means
4. Rx is medically appropriate (defendant's best medical interest)	3. Proposed tx plan narrowly tailored... + 4. Proposed Rx will not cause unreasonable risk to def's health + HCG to advise re best medical interest if incapable of informed consent

CT Legislative Response to Sell

- PA 04-160, effective Oct 1, 2004
 - Calls for appointment of Special Limited Conservator (SLC) if defendant incapable of informed consent re Rx and Rx needed for tx
 - SLC to review risks/benefits of Rx, likelihood and seriousness of side effects, patient preferences, patient's religious views, and prognosis with and without Rx
 - SLC consents or withholds consent

CT Legis. Response to Sell (#2)

- If defendant capable of informed consent, but refusing Rx, and conditions places patient or others in “direct threat of harm” probate court may order invol Rx
- Codified at 17a-543a, just after 17a-543 which deals with conservators and probate court
- No provision for invol Rx of non-dangerous defendant capable of informed consent

Difficulties – potential & real

- Statutes do not specify whether “Garcia” or “Sell” rules have priority
 - Although CT SC says “*Garcia* was superseded by *Sell*” (in another 2003 decision)
- SLC placed in probate court section, not in CST section
- “Sell” statutes do not satisfy *Sell* dicta re relative order of methods (but should we care?)

The Experience So Far

from

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Old and New Systems

“Garcia” Statute

- CT State Supreme Ct
- 1995 and following
- Part of CST Statutes
- Criminal Court
- Health Care Guardian to give an opinion
- Judge decides if medications will be given

“Sell” Statute

- US Supreme Ct
- 2003 and following
- Part of Probate/MH Laws
- Probate Court
- Special Limited Conservator to evaluate
- SLC decides if medications will be given

Old and New Systems (#2)

“Garcia” Statute

- Defendant “will not attain competency within the remainder of the period covered by the placement order absent administration of psychiatric medication for which the defendant is unwilling or unable to give consent.”

“Sell” Statute

- Defendant “is incapable of giving informed consent to medication for the treatment of such patient’s psychiatric disabilities and such medication is deemed to be necessary for such patient’s treatment.”

Old and New Systems (#3)

“Garcia” Statute

- 1. Treatment will render defendant competent
- 2. Adjudication cannot be had using less intrusive means
- 3. Proposed treatment plan is narrowly tailored to minimize intrusion on liberty and privacy interests
- 4. Proposed treatment plan will not cause unnecessary risk to health
- 5. Seriousness of alleged crime is such that state has overriding interest in fairly and accurately determining guilt

“Sell” Statute

- 1. Treatment of psychiatric disabilities is deemed necessary
- 2. N/A
- 3. SLC will: meet with the patient and physician; consider the written record; consider the patient’s preferences and religious views
- 4. SLC will consider: risks and benefits of the medication; likelihood and seriousness of adverse side effects; prognosis with and without treatment
- 5. N/A

Old and New Systems (#4)

“Garcia” Statute

- No mention of time limits for medication administration
- 2007 amendment: Invol Rx order may be continued to maintain competency upon return to DOC
- No mention of relationship to new statute
- Remains available to courts for use

“Sell” Statute

- Authority of SLC must be renewed every 120 days
- No mention of procedures to be followed after patient restored to competency
- No mention of relationship to old statute

Transition to New System

- After passage of new statute, and in light of State Supreme Court decision saying “Sell supersedes Garcia”, decision made in Autumn 2004 at hospital to refer **all** new cases of involuntary medication for restoration of competence to stand trial to the Probate Court. Some cases under the old statute were still in the hospital being treated.

Data Sept 2004- June 2009

- Total CSTR admissions – 758 (mean 16.5 / mo)
 - SLC petitions – 82 (11%)
 - Petitions granted – 73 (89%)
 - Restored – 62 (85%)
 - HCG petitions – 6 (0.8%)
 - 3 after failed SLC petitions
 - 1 HCG appointed
 - 3 w/o prior SLC petitions
 - 3 HCGs appointed
 - Restored – 4 (100%)

LOS Data

- SLC cases (n=73) - Median days:
 - Admission to hearing – 50 (sd 40)
 - Hearing to disposition – 123 (sd 81)
 - Admission to disposition – 179 (sd 95)
- HCG cases (n=4) – Median days:
 - Admission to hearing – 50
 - Hearing to disposition –
 - Admission to disposition – 168
 - (very large ranges)

Probate Court Perspective on Involuntary Medication to Restore Competence to Stand Trial in CT

from

Hon. Joseph D. Marino

Court of Probate

Middletown, CT

Language of Statute is Relatively Simple

- Judicial confirmation (by clear and convincing evidence) of determination made by “head of the hospital” and “two qualified physicians” that
 - patient undergoing competency restoration is incapable of giving informed consent to medication
 - medication necessary for treatment
- Hearing is held at the facility in which patient is represented by an attorney

What I Do

Overlay of *Sell v. U.S.* language over
our CT Statute

Questions that must be addressed by patient's treating psychiatrist

1. The administration of drugs is “substantially likely” to render patient competent to stand trial.
2. Any adverse side effects from the medication?
3. Any alternative, less intrusive, treatment?

Balancing Test

Need for treatment versus patient's constitutionally protected liberty interest in "avoiding the unwanted administration of antipsychotic drugs"

Washington v. Harper, 494 U.S. 210, 221 (1990)

DENIALS

The cases in which the appointment of a Special Limited Conservator was denied failed different aspects of the “tests” set forth above

Example 1

- Unclear medical history and question of possible adverse side effects from prior medications. Patient refused to sign releases.
- Solution – Appointment of a “traditional” Conservator (i.e. with no medication authority) to circumvent patient and sign releases to obtain medical history to determine appropriate clinical action.

Example 2

- Patient did not need medication for treatment.
- Presented to court as coherent and rational with relatively minor criminal charges.
- Patient could deal with the criminal justice system without forcing medications.

Example 3

- Patient charged with murder.
- Failed the “balancing test”, - i.e. protected liberty interest superseded need for treatment.
- State could still obtain forced medication order but under much more stringent statutory standard.

Time flies like an arrow.
Fruit flies like a banana.

- Groucho Marx

Questions / Discussion