

# **Psychotropic Medications and Criminal Defendants**

## **Refusals of psychotropic medication by detained criminal defendants raise conflicting dual loyalties for psychiatrists between the duty to treat a patient and the duty to protect society from that patient.**

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The right of individuals with severe mental illness to refuse prescribed psychotropic medication has been one of the major issues in mental health law over the last quarter century in the United States.

Treatment refusal as an issue has arisen in numerous clinical and legal contexts such as patients hospitalized in psychiatric facilities, treated as outpatients in the community, detained in jails prior to trial, incarcerated in prisons after conviction—or prior to execution in the case of prisoners on death row. The issue of treatment refusal has primarily concerned patients who have been civilly committed to a psychiatric hospital. Interested parties in this debate have included not only the individuals themselves, but also the treating psychiatrists, family members, and facility administrators, all of whom have generally advocated for overriding treatment refusals.

In many cases, treatment of individuals with severe mental illness is not strictly voluntary. Family members, probation officers, employers, and professional state boards prescribe or order psychotropic medications to individuals who do, in fact, have a choice whether or not to accept that treatment. The available alternative might be loss of family financial support, incarceration, loss of employment, and sanction on a professional license. In these situations, we often refer to the individual's decision as coerced, which reflects the presence of some retained voluntariness of decisionmaking. When the individual is unable to refuse that treatment, we refer to the treatment being compelled, not coerced.

Refusal of psychotropic medication became an important and controversial issue in the 1970s, in part, due to the risks of antipsychotic medication available at the time. These risks included the movement disorders tardive dyskinesia and tardive dystonia, which were thought to be prevalent, irreversible, and untreatable. Additional concerns were the erroneous belief that antipsychotic medication constituted exogenous mind, thought, and behavioral control. More recently developed atypical antipsychotic medications have minimal known risk of movement disorders, so that this adverse drug effect can no longer be a significant basis for treatment refusal.

Legal, constitutional arguments underlying treatment refusal have included the First Amendment's freedom of religious expression and the Fourteenth Amendment's due process protections. Constitutional principles and the common law tort of battery provide individuals with a right to bodily autonomy and integrity and freedom from bodily intrusions. In addition, legal and ethical requirements of informed consent to medical treatment are pertinent here and are predicated upon respect for the patient's autonomy and an expectation that the patient can participate meaningfully in making responsible treatment decisions.

### **Exceptions to consent rules**

It is important to note, however, that there are exceptions to the requirements of informed consent. One exception is an emergency situation, usually involving physical harm to the patient or others. Another exception to the informed

consent requirements is incapacity or incompetence of the individual to make responsible treatment decisions. Both of these exceptions are used as criteria for deciding whether and when to override treatment refusals by psychiatric patients.

A critical distinction has been made between treatment refusals by patients with medical illnesses and those with psychiatric illnesses. Unlike medical diseases, severe psychiatric disorders are often characterized by impaired awareness of illness. Delusional patients, for example, remain convinced of the reality of their particular delusion regardless of others' attempts to convince them to the contrary. Individuals with schizophrenia, delusional disorder, or mood disorders with psychotic symptoms who are not on appropriate psychotropic medication often have limited or no insight into the presence and extent of their disorder.

States have adopted different legal mechanisms for resolving such disputes on behalf of hospitalized psychiatric patients. These procedures were often adopted as a result of litigation but sometimes by state statute or regulation. Many states require that the patient be adjudicated incompetent to refuse psychotropic medication by a court prior to involuntarily medicating that patient. That procedure typically causes a delay in instituting treatment, which incurs risks to the patient's safety and that of other patients and staff if the patient is untreated for months. Other states have adopted an administrative review proceeding which does not require a court hearing, prior to forcing medication. Criteria for overriding treatment refusals at these administrative or judicial review proceedings include:

- the presence of severe mental illness,
- need for treatment,
- treatability of the individual with medication ,
- incapacity or incompetence of the individual to make responsible treatment decisions,
- risk of physical harm to the patient or others absent treatment.

It may be necessary to establish that psychotropic medication is the least intrusive treatment that meets the patient's treatment needs.

Empirical research on treatment refusal has been conducted, usually on treatment-refusing hospitalized patients. That research has shown that, in jurisdictions using a judicial review procedure, courts have adjudicated the patient to be incompetent to refuse medication and ordered involuntary medication in the vast majority of cases.

A basic issue is the clinical outcome of individuals compelled to accept medication while hospitalized. One outcome is that the forcibly medicated patient, once treated, develops insight into the presence and severity of illness, and becomes able to say "thank you" to the treatment team. Another result is that some forcibly medicated patients remain unwilling to take medication, do not develop insight into their illness, and become even more resistant to subsequent treatment.

## **Trial competence**

Refusals of psychotropic medication by detained criminal defendants raise similar, but additional, issues to those in civil psychiatric hospitals. In most criminal prosecutions, it is necessary for the defendant to be legally competent to stand trial prior to trial. A similar competency finding is needed prior to sentencing. Our respect for human dignity requires that society punish only those who are adequately aware of the criminal process and able to participate in it. The specific criminal competence criteria are defined by case law or statute, whether federal or state, but usually entail the requirements that the defendant understand the nature and object of the criminal proceedings against him and be able to assist counsel in his defense. If the trial court finds that the defendant is not criminally competent to stand trial due to a severe mental disorder, then the court typically orders a course of treatment designed to restore the defendant's competence. The incompetent defendant is usually transferred to a secure or forensic mental health facility that specializes in the care of such defendants. Nonpharmacologic, psychoeducational treatment approaches are often useful in restoring the defendant's trial competence, but these do not directly treat the underlying mental disorder.

Though the law sometimes places time limits on the incompetent defendant's psychiatric treatment, refusal of necessary psychotropic medication by the defendant prolongs or forestalls restoration of competence and return of the

defendant to jail for trial. Severely mentally ill defendants, absent treatment, often are isolated from other defendant-patients, and can further deteriorate both mentally and physically. Criminal defendants have refused psychotropic medication for fear that the medication would compromise their cognitive functioning and interfere with their ability to consult with counsel, testify, or understand the trial proceedings. Others have refused treatment based upon a wish to present their true mentally ill state to the jury in pursuit of an insanity defense, with the fear that medication would alter their appearance or demeanor. These arguments relate to the possibility of compromising the defendant's right to a fair trial.

In contrast to the defendant's argument that forcible medication abrogates his right to a fair trial, the prosecution contends that society has a valid interest in convicting, and punishing, individuals who commit crimes. A corollary of the argument is that a defendant should not be permitted to escape prosecution by refusing necessary psychiatric treatment, which could restore his trial capacity. In the ordinary, voluntary clinical setting, treating psychiatrists act on behalf of patients and in their best medical-psychiatric interests. Even in the ordinary, voluntary clinical setting, treating psychiatrists have limited legal and ethical duties to protect third parties from their potentially violent patients. To the extent that the treating psychiatrist in a forensic mental health facility seeks to forcibly medicate the defendant to treat a defendant's mental disorder, the psychiatrist is acting in the best medical-psychiatric interests of the defendant although paternalistically. When issues of risk of violence to other patient-defendants or staff arise due to treatment refusal, the treating psychiatrist who seeks to medicate the defendant forcibly is acting on behalf of third parties, not directly for the patient. In contrast, to the extent that the treating psychiatrist seeks to medicate the nonviolent defendant forcibly to restore the defendant's trial competence, that psychiatrist is acting as an agent of the state at large. Even those treating psychiatrists employed in public, forensic mental health facilities, and state-salaried, likely view themselves as agents of the patient-defendant, rather than agents of the state.

## Dual loyalties?

Dual loyalties for psychiatrists often present role conflicts, some of which may be irreconcilable at times. The duty to treat the patient can readily conflict with the duty to protect society from that patient or to warn society. In such situations, psychiatrists attempt to mitigate the conflict by implementing the third-party duty in as therapeutic a manner as possible. For example, psychiatrists attempt to constructively involve the patient in the effort to protect the third party, thus enhancing the patient's autonomy and self-esteem. Still, the third-party duty typically trumps the duty to serve the patient's interest in matters of life and death or of serious physical harm to the patient. In the context of the pretrial criminal defendant, involuntarily medicating the nonviolent defendant treats the underlying severe mental disorder while also helping to restore trial competence.

Courts, too, attempt to resolve the inherent conflict between permitting the defendant to refuse psychotropic medication and compelling it [1]. Courts can authorize involuntary medication on grounds of danger to the patient or others rather than restoration of trial competence. Otherwise, courts seek to order medication when it is necessary to restore trial competence, when it is medically appropriate, and when alternative, less intrusive intervention is unlikely to obtain the same results, so long as the medication does not cause significant adverse effects to the defendant's health or compromise the defendant's right to a fair trial [2, 3].

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## References

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