

January 2017

## Retributive Medication: A Discussion of a Maine Law Allowing Involuntary, Forcible Medication of a Pretrial Defendant for the Purpose of Rendering the Defendant Competent to Stand Trial

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### Recommended Citation

Ashley T. Perry, *Retributive Medication: A Discussion of a Maine Law Allowing Involuntary, Forcible Medication of a Pretrial Defendant for the Purpose of Rendering the Defendant Competent to Stand Trial*, 69 Me. L. Rev. 137 (2017).

Available at: <https://digitalcommons.mainerlaw.maine.edu/mlr/vol69/iss1/5>

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# RETRIBUTIVE MEDICATION: A DISCUSSION OF A MAINE LAW ALLOWING INVOLUNTARY, FORCIBLE MEDICATION OF A PRETRIAL DEFENDANT FOR THE PURPOSE OF RENDERING THE DEFENDANT COMPETENT TO STAND TRIAL

*Ashley T. Perry*

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# RETRIBUTIVE MEDICATION: A DISCUSSION OF A MAINE LAW ALLOWING INVOLUNTARY, FORCIBLE MEDICATION OF A PRETRIAL DEFENDANT FOR THE PURPOSE OF RENDERING THE DEFENDANT COMPETENT TO STAND TRIAL

Ashley T. Perry\*

## I. INTRODUCTION

In September 2015, prosecutors filed a motion in Kennebec County Superior Court, Maine, before Justice Donald Marden, to force antipsychotic medication upon Leroy Smith III, a defendant charged with the gruesome murder of his father.<sup>1</sup> Smith, who was twenty-four years old at the time of the murder,<sup>2</sup> suffers from delusional disorder and was declared incompetent to stand trial,<sup>3</sup> after exhibiting “bizarre” behavior at an initial hearing less than a week after the killing and undergoing a forensic evaluation.<sup>4</sup> However, before that determination, Smith had confessed to killing his father in their apartment<sup>5</sup> by stabbing him in the head and neck, dragging his body into the bathtub, cutting it up into small pieces, putting those pieces into trash bags, and dumping the bags in nearby woods.<sup>6</sup> In Smith’s confession to the police, Smith said he “filleted” his father and buried him because his father sexually assaulted him throughout his life.<sup>7</sup>

Smith has been held at Riverview Psychiatric Recovery Center in Augusta, Maine, since the declaration of incompetence.<sup>8</sup> For the first time in a Maine state

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\* J.D. Candidate, University of Maine School of Law, Class of 2017. The Author would like to thank Jamesa Drake, Esq., for her wisdom and guidance during the drafting of this Comment. The Author is also exceedingly grateful for the endless support of her husband, Jake.

1. Eric Russell, *State’s Effort to Force Drug on Defendant Before Trial Sparks Debate*, PORTLAND PRESS HERALD (Sept. 20, 2015), <http://www.pressherald.com/2015/09/20/states-effort-to-force-drug-on-defendant-before-trial-sparks-debate>; Betty Adams, *Leroy Smith III, Accused of Murder, Hears Lawyers Debate Medicating Him Involuntarily*, CENTRAL MAINE (Dec. 2, 2015), <http://www.centralmaine.com/2015/12/02/leroy-smith-iii-accused-of-murder-hears-lawyers-argue-over-involuntarily-medicating-him>.

2. Betty Adams, *Maine Murder Suspect Says He “Filleted” His Father*, PORTLAND PRESS HERALD (May 8, 2014), [http://www.pressherald.com/2014/05/08/gardiner\\_man\\_charged\\_with\\_killing\\_father\\_claims\\_he\\_s\\_a\\_political\\_prisoner](http://www.pressherald.com/2014/05/08/gardiner_man_charged_with_killing_father_claims_he_s_a_political_prisoner).

3. Psychiatric Nurse Practitioner, Miriam Davidson, who has worked with Smith at Riverview Psychiatric Recovery Center since he arrived in 2014, has diagnosed Smith with delusional disorder but has not ruled out schizophrenia. Beth Brogan, *Defense: Forced Meds Won’t Make Accused Maine Killer Competent for Trial*, BANGOR DAILY NEWS (Dec. 2, 2015), <http://bangordailynews.com/2015/12/02/news/state/defense-forced-meds-wont-make-accused-maine-killer-competent-for-trial>.

4. See Russell, *supra* note 1.

5. Smith’s confession, as a mentally incompetent defendant, raises several issues regarding the admissibility of the confession in a court of law under State and Federal Rules of Evidence and Fourteenth Amendment Due Process considerations. However, those specific issues are beyond the scope of this Comment.

6. See Russell, *supra* note 1; Adams, *supra* note 1.

7. Adams, *supra* note 1.

8. Russell, *supra* note 1.

court, prosecutors relied on a new state law which allows involuntary medication of a defendant who has been declared incompetent for the purpose of restoring competency to stand trial, provided certain conditions are met.<sup>9</sup> In November 2015, Justice Marden granted the State's motion to allow the State access to the Riverview treatment records of Smith.<sup>10</sup> In January 2016, Justice Marden ordered Smith to be forcibly medicated to stand trial.<sup>11</sup>

This Comment does not discuss in depth the details of the case against Smith. Instead, this Comment explores the underlying issues—involuntary medication and the fundamental right to be free in the privacy of one's person, especially for a presumed-innocent defendant whose case is in pretrial posture—and discusses the new Maine law which allowed the forcible medication of Smith. Though the law is constitutional under precedent of the United States Supreme Court,<sup>12</sup> the requisite conditions are extremely unlikely to be satisfied. The law is also unnecessary in the State of Maine, when taken into consideration with Maine's existing policies and procedures.

Part II of this Comment discusses the provisions of the United States Constitution that are relevant to this Comment, as well as the provisions of the Maine State Constitution that are relevant to this Comment. Part III of this Comment discusses the legislative history of the Maine law at issue, called "An Act Regarding Treatment of Forensic Patients," along with the federal background which helps set the stage for the discussion. Part IV of this Comment discusses the issue of mental illness in both the federal legal system, and the State of Maine's legal system. This includes discussion of the history of mental illness and insanity pleas, and how the issues have changed over time in the Federal system and in Maine. This section also includes a description of the process of guardianship and the process of medical treatment in Maine. Part V of this Comment discusses the morality of forcibly medicating a pretrial defendant. This includes the deprivation of fundamental rights and the lack of legitimate penological purpose in forcibly medicating a pretrial defendant for the sole purpose of rendering the defendant competent to stand trial.

Part VI of this Comment discusses the factors created by the United States Supreme Court in *Sell v. United States*, which must be present before a defendant can be forcibly medicated. This part discusses each of the four *Sell* factors: (1) the treatment is medically appropriate; (2) the treatment is substantially unlikely to have side effects that may undermine the fairness of the trial; (3) the court has considered less intrusive alternatives; and, (4) the treatment is necessary to significantly further important governmental trial-related interests. This part further discusses why each individual *Sell* factor is extremely difficult to satisfy.

Finally, Part VII of this Comment concludes that, notwithstanding the fact that the law is constitutional under United States Supreme Court precedent, the nature of the requisite conditions and Maine's existing policies and procedures render the law

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9. 15 M.R.S.A. § 106 (2015).

10. Betty Adams, *Leroy Smith III, Accused of Killing His Father, to be in Court Dec. 1*, CENTRAL MAINE (Nov. 2, 2015), <http://www.centralmaine.com/2015/11/02/leroy-smith-iii-accused-of-killing-his-father-to-be-in-court-dec-1>.

11. Sharon Handy, *Judge Orders Murder Suspect to be Involuntarily Medicated*, WMTW NEWS (Jan. 8, 2016), <http://www.wmtw.com/news/judge-orders-murder-suspect-to-be-involuntarily-medicated/37335612>.

12. See *infra* Part VI.

unnecessary and incompatible with the State of Maine.

## II. CONSTITUTIONAL FOUNDATION

### A. *United States Constitution*

Several amendments of the United States Constitution are pertinent to the discussions of this Comment, including the Fourteenth, Sixth, and Fifth Amendments. The Fourteenth Amendment of the United States Constitution provides due process protections for United States citizens.<sup>13</sup> The Sixth Amendment of the United States Constitution confers, among other rights, a right for criminal defendants to be informed of the charge and witnesses against them, as well as effective assistance of counsel.<sup>14</sup> The Fifth Amendment confers a right to be free from deprivation of life, liberty, or property, without due process of law.<sup>15</sup>

### B. *Maine State Constitution*

To the extent that it tracks the Federal Constitution, there are several amendments of the Maine State Constitution which are pertinent to the discussions of this Comment as well. The Constitution of the State of Maine provides protections to accused persons from deprivation of liberty, except by “judgment of that person’s peers or the law of the land”<sup>16</sup> and from deprivation of liberty “without due process of law.”<sup>17</sup> Additionally, due process protections of the United States Constitution are afforded to the citizens of Maine against the actions of the State by the Due

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13. U.S. CONST. amend. XIV § 1 (“All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.”).

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

15. U.S. CONST. amend. V (“No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.”).

16. ME. CONST. art. I, § 6 (“In all criminal prosecutions, the accused shall have a right to be heard by the accused and counsel to the accused, or either, at the election of the accused; To demand the nature and cause of the accusation, and have a copy thereof; To be confronted by the witnesses against the accused; To have compulsory process for obtaining witnesses in favor of the accused; To have a speedy, public and impartial trial, and, except in trials by martial law or impeachment, by a jury of the vicinity. The accused shall not be compelled to furnish or give evidence against himself or herself, nor be deprived of life, liberty, property or privileges, but by judgment of that person's peers or the law of the land.”).

17. *Id.* at § 6-A (“No person shall be deprived of life, liberty or property without due process of law, nor be denied the equal protection of the laws, nor be denied the enjoyment of that person's civil rights or be discriminated against in the exercise thereof.”).

Process Clause of the Fourteenth Amendment.<sup>18</sup>

### III. LEGAL BACKGROUND

#### A. Maine Law: “An Act Regarding Treatment of Forensic Patients”

The new Maine law at issue, 15 M.R.S. § 106, along with §§ 107 and 108, was enacted as part of “An Act Regarding Treatment of Forensic Patients.” An amendment to the bill, LD 1391, included language about the purpose of the Act reflecting the need to protect hospital staff and reduce costs based on injuries sustained by hospital staff.<sup>19</sup> The legislative history of the bill reveals that the original language of the bill read, in part, “the medication . . . [i]s substantially likely to render the defendant competent to *stand trial*.”<sup>20</sup> The language of the bill changed from “to stand trial” to “to proceed,”<sup>21</sup> with no mention of trial anywhere in the law.<sup>22</sup>

Additionally, there was mixed public hearing testimony which the Maine Legislature received in support or opposition to the bill. Testimony in opposition to the bill included Oamshri Amarasingham, Public Policy Counsel for the American Civil Liberties Union (ACLU) of Maine and Jenna Mehnert for the National Alliance on Mental Illness (NAMI). The ACLU of Maine testified that the group opposes forced medication in any form, based on “fundamental civil liberties [of] . . . autonomy and self-determination . . .”<sup>23</sup> The group maintained that a person never loses “decisional capacity,” so the right to refuse treatment is never diminished.<sup>24</sup> The group further proposed that a guardian should be appointed for the patient, separate from that patient’s attorneys, to make decisions in the patient’s best interest.<sup>25</sup>

On the other hand, NAMI, opposed the concept of allowing prosecuting attorneys to force treatment upon a defendant under the rationale of “state interest” because it does not comport with the goal of recovery, which should be the “guiding principle” in mental health services.<sup>26</sup> A process that allows the patient to accept his or her treatment and assist in developing his or her own recovery plan is a preferable and more effective treatment process.<sup>27</sup>

There was also public hearing testimony received in favor of the bill. However, the testimony is largely inapplicable to certain factual scenarios that may be before

18. “The Fourteenth Amendment denies the States the power to ‘deprive any person of life, liberty, or property, without due process of law.’” *Duncan v. Louisiana*, 391 U.S. 145, 147 (1968) (citing U.S. CONST. amend. XIV § 1.).

19. Hous. Amend. “A” to LD 1391 (127th Legis. 2014).

20. Comm. Amend. to LD 1391 (127th Legis. 2014) (emphasis added).

21. *Id.*

22. 15 M.R.S.A. § 106 (2015).

23. *An Act Regarding the Treatment of Forensic Patients: Hearing on LD 1391 Before the J. Standing Comm. on Judiciary*, 127th Legis. (2014) (testimony of Oamshri Amarasingham, Esq., Public Policy Counsel for the ACLU of Maine).

24. *Id.*

25. *See id.*

26. *An Act Regarding the Treatment of Forensic Patients: Hearing on LD 1391 Before the J. Standing Comm. on Judiciary*, 127th Legis. (2014) (testimony of the NAMI Maine) (explaining that “involuntarily medicating forensic patients for the purpose of restoring competency is about prosecution.”).

27. *Id.*

a Maine court. For example, the Legislature received testimony from an individual who had worked in Maine at the Augusta Mental Health Institute, Riverview Psychiatric Center, and the Riverview Psychiatric Recovery Center. This individual maintained that medical treatment of psychiatric patients is “imperative” to the recovery of patients to be returned to the community.<sup>28</sup> However, this testimony ignores the reality of forensic patients who have committed crimes that make their return to the community extremely unlikely; instead, they face a future in prison or psychiatric centers.

Additionally, Susan Lamb, Executive Director of the Maine Chapter of the National Association of Social Workers (NASW), testified in support of the bill.<sup>29</sup> However, her testimony acknowledged the NASW’s concern of a mentally ill defendant, found incompetent to stand trial, forcibly medicated and then later moved from a therapeutic setting of a psychiatric hospital to incarceration.<sup>30</sup> This actually supports the concerns expressed during testimony of NAMI, that forced medication undermines the goal of mental health services.

### B. Federal Background

The foundation of LD 1391, which was introduced to the Legislature by Richard Malaby of Maine House District 136, was based on two United States Supreme Court cases: *Washington v. Harper* and *Sell v. United States*.<sup>31</sup> In *Harper*, the Department of Corrections for the State of Washington had a “Special Offender Center” to treat and diagnose prisoners with mental disorders.<sup>32</sup> The center had a written procedural policy to determine the appropriateness of medication, and defendant Harper was involuntarily treated with antipsychotic drugs following involuntary treatment proceedings.<sup>33</sup> Harper challenged the treatment, arguing that involuntary administration of antipsychotic drugs without a judicial hearing is a violation of due process rights.<sup>34</sup> The Supreme Court held that the United States Constitution permits forced medication of prison inmates with antipsychotic medication if the inmate is a danger to himself or others, or the treatment is in the “medical interest” of the inmate.<sup>35</sup> The decision in *Harper* helped, in part, to pave the way for the later decision of *Sell*.

In *Sell*, the defendant, formerly a practicing dentist, had a long history of mental

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28. *An Act Regarding the Treatment of Forensic Patients: Hearing on LD 1391 Before the J. Standing Comm. on Judiciary*, 127th Legis. (2014) (testimony of Laura Fisher, President of the American Federation of State, County and Municipal Employees (AFSCME) Maine).

29. *An Act Regarding the Treatment of Forensic Patients: Hearing on LD 1391 Before the J. Standing Comm. on Judiciary*, 127th Legis. (2014) (testimony of Susan Lamb, Executive Director of the Maine Chapter of the NASW).

30. *Id.*

31. *An Act Regarding the Treatment of Forensic Patients: Hearing on LD 1391 Before the J. Standing Comm. on Judiciary*, 127th Legis. (2014) (introductory testimony of Richard Malaby, Representative of ME House Dist. 136).

32. *Washington v. Harper*, 494 U.S. 210, 214 (1989).

33. *Id.* at 217.

34. *Id.*

35. *Id.* at 227 (“[G]iven the requirements of the prison environment, the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate’s medical interest.”).

illness, but was originally found by a magistrate to be competent to stand trial for fraud.<sup>36</sup> The Magistrate later revoked Sell's bail because his mental condition had worsened, according to testimony at a bail revocation hearing, after a grand jury returned a new indictment for a charge of tampering with a witness.<sup>37</sup> The witness tampering case was joined with the fraud case for trial.<sup>38</sup> Sell was later found incompetent to stand trial, and the magistrate authorized involuntary administration of antipsychotic medication.<sup>39</sup> The Supreme Court remanded for further proceedings, but held that:

[T]he Constitution permits the Government involuntarily to administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial, but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests.<sup>40</sup>

In addition to *Harper* and *Sell*, other cases have laid precedent for states to rely upon in addressing involuntary medication of defendants. For example, *Riggins v. Nevada* has also set a precedent related to requirements of involuntary treatment.<sup>41</sup> In *Riggins*, prior to *Sell*, the United States Supreme Court held that if a defendant refuses antipsychotic medication, the State is obligated to establish the necessity and appropriateness of the medication, and also to address possible alternatives.<sup>42</sup>

### C. Summary

The State of Maine enacted LD 1391, “An Act Regarding the Treatment of Forensic Patients,” [hereinafter “the Act”] in 2015. The new law allows for involuntary medication of a defendant declared incompetent, for the sole purpose of restoring competency to stand trial, provided certain conditions are met. The purpose of the law is purportedly based on the need to protect hospital staff and reduce costs of mental hospitals. However, the purpose of involuntarily medicating a pretrial defendant to restore competency to stand trial is not based on the need to protect hospital staff. Rather, the purpose of such involuntary medication is to fulfill retributive functions of criminal justice – essentially, to start the process of punishing the defendant for his crimes.<sup>43</sup> The doctrinal support for the new law rests on *Washington v. Harper* and *Sell v. United States*. However, the factors laid out in *Sell*, which allow a state to involuntarily medicate a defendant who has been deemed incompetent to stand trial, are exceptionally difficult in and of themselves to satisfy. Additionally, the existing policies and procedures in Maine make the *Sell* factors even less likely to be satisfied, rendering the law ultimately unnecessary for Maine.

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36. *Sell v. United States*, 539 U.S. 166, 169-70 (2003).

37. *Id.* at 170.

38. *Id.*

39. *Id.* at 171, 173.

40. *Id.* at 179.

41. See generally *Riggins v. Nevada*, 504 U.S. 127 (1992).

42. *Id.* at 135.

43. The implications of this will be further discussed *infra* Part V, Section B.



## IV. MENTAL ILLNESS IN THE LEGAL SYSTEM

*“Every human being of adult years  
and sound mind has a right  
to determine what shall be done with his own body”*  
—Justice Benjamin N. Cardozo<sup>44</sup>

*A. Mental Illness in the Federal System*

It has been only relatively recently that mental disability and illness have been taken seriously in the legal system. Mental illness was historically addressed in the legal system by the civil commitment of an offender. For example, states utilized the process of commitment to psychiatric centers at least as early as the middle 19th Century, relying on principles of “*parens patriae*,” and later “police powers.”<sup>45</sup> States exercised these powers without concern for the rights of the patients. Patients were committed for the protection of the patient and the public, because the patient “was incapable of acting in his or her own welfare.”<sup>46</sup>

True due process considerations concerning the commitment of patients did not arise until about the 1970s.<sup>47</sup> In 1972, the United States Supreme Court decided *Humphrey v. Cady*, which reversed a sentence for indefinite civil commitment, referring to such commitment as “a massive curtailment of liberty.”<sup>48</sup> Within the same year, the Court created a due process requirement of “reasonable relation,” that is, the “nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.”<sup>49</sup> The Court significantly expanded due process rights concerning commitment in 1975 in *O’Connor v. Donaldson*, holding that the commitment process must abide by constitutional principles.<sup>50</sup> Later, in *In re Winship*, the Court emphasized the importance of what society considers to be fair, and what instills confidence in the criminal justice system.<sup>51</sup>

Fortunately, after decades of just *dealing with* mental illness, the legal system began to strive toward *understanding* mental illness. In 2002, the Supreme Court decided the landmark case of *Atkins v. Virginia*. In *Atkins*, the Virginia Supreme Court affirmed a conviction and sentence of a mentally disabled man, convicted of capital murder and sentenced to death.<sup>52</sup> The Supreme Court reversed, holding that execution of a mentally disabled individual constitutes cruel and unusual

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44. Schloendorff v. Soc’y of NY Hosp., 105 N.E. 92, 93 (N.Y. 1914).

45. David F. Mrad, *The Pre-Sell Medication Controversy: Restoring Competency at the End of the 20th Century*, 37 J. Psychiatry & L. 341, 342 (2009).

46. *Id.*

47. *Id.* at 343.

48. *Id.* (quoting *Humphrey v. Cady*, 405 U.S. 504, 509 (1972)).

49. *Id.* (quoting *Jackson v. Indiana*, 406 U.S. 715, 738 (1972)).

50. *Id.* at 344 (quoting *O’Connor v. Donaldson*, 422 U.S. 563 (1975)).

51. 397 U.S. 358, 364 (1970) (“It is also important in our free society that every individual going about his ordinary affairs have confidence that his government cannot adjudge him guilty of a criminal offense without convincing a proper factfinder of his guilt with utmost certainty.”).

52. *Atkins v. Virginia*, 536 U.S. 304, 310 (2002).

punishment,<sup>53</sup> prohibited under the Eighth Amendment.<sup>54</sup> The Court reasoned that the large number of states which already prohibited such execution evidenced a broad societal view of mentally disabled “offenders as categorically less culpable than the average criminal.”<sup>55</sup> Mentally disabled individuals may be competent, but also may have “diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand others’ reactions.”<sup>56</sup> Execution is excessive punishment for mentally disabled criminals, due to diminished culpability and low impulse control; therefore, execution does not serve its primary goals of retribution and deterrence with mentally disabled offenders.<sup>57</sup> Most importantly, the impairments of mentally disabled offenders give such defendants a “special risk of wrongful execution.”<sup>58</sup>

Federal law in the United States has utilized several tests to determine the sanity of a defendant. The traditional insanity test is called the “*M’Naghten* Rule.” The Rule is based on an English criminal case in the 1800s,<sup>59</sup> in which the defendant tried to kill Sir Robert Peel, the Prime Minister, but mistakenly shot Sir Robert Peel’s secretary at the Prime Minister’s home.<sup>60</sup> Several medical experts testified as to the insanity of M’Naghten, as did two impartial physicians summoned to testify by the court.<sup>61</sup> M’Naghten was found not guilty of the crime by reason of insanity.<sup>62</sup> Out of this case developed the *M’Naghten* Rule, used to establish insanity.

The *M’Naghten* Rule has three prongs. First, the accused must have some mental illness or defect.<sup>63</sup> Second, the mental illness or defect must deprive the accused of the “ability to understand the nature and quality of his actions or their wrongfulness.”<sup>64</sup> Lastly, the accused must have suffered from the mental illness or defect at the time of the crime.<sup>65</sup> However, an additional prong was later added to the traditional insanity test in most jurisdictions, called the “irresistible impulse” test.<sup>66</sup> In addition to the *M’Naghten* Rule, the “irresistible impulse” test determines whether the defendant is entitled to acquittal, because his mental illness resulted in an inability to control himself, and he was “overcome by an irresistible impulse to

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53. *Id.* at 321.

54. U.S. CONST. amend. VIII (“Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.”).

55. *Atkins*, 536 U.S. at 304.

56. *Id.* at 305.

57. *Id.*

58. *Id.* (“[M]entally retarded defendants in the aggregate face a special risk of wrongful execution because of the possibility that they will unwittingly confess to crimes they did not commit, their lesser ability to give their counsel meaningful assistance, and the facts that they are typically poor witnesses and that their demeanor may create an unwarranted impression of lack of remorse for their crimes.”).

59. Daniel M’Naughten’s Case [1843] 8 Eng. Rep. 718 (appeal taken from Scot.).

60. Marvin H. Firestone, *Psychiatric Patients and Forensic Psychiatry*, in *LEGAL MEDICINE* 621, 623 (Am. Coll. of Legal Med. ed., 7th ed. 2007).

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.*

66. 24 JAMES WM. MOORE ET AL., *MOORE’S FEDERAL PRACTICE*, § 612.2 (3d ed. 2015).

commit the crime.”<sup>67</sup>

Congress later adopted the Insanity Defense Reform Act of 1984, the first legislative act regarding the insanity defense,<sup>68</sup> possibly as a response to growing criticisms of the existing insanity tests.<sup>69</sup> The Act adopted some of the insanity test proposed by the American Law Institute (ALI),<sup>70</sup> but specifically eliminated a “volitional” requirement—or an “irresistible impulse” test—proposed by the ALI.<sup>71</sup> The implications of this exclusion of a volitional requirement were critical—the exclusion meant that no longer would the defendant’s inability to control himself be exculpatory.<sup>72</sup> The defendant must truly lack the ability to understand the “nature and quality of his actions or their wrongfulness.”<sup>73</sup> The Act shifted the burden of proof to the defendant, requiring proof of the insanity defense by “clear and convincing evidence.”<sup>74</sup> The Act also created the “not guilty only by reason of insanity” verdict, which triggers automatic commitment proceedings.<sup>75</sup> Nonetheless, the Act is unlikely to be the end of the road in the development of the insanity defense.<sup>76</sup>

## B. Mental Illness in the State of Maine

### 1. History of Mental Illness in Maine

Maine has also gone through a transition in the treatment of mental illness in the legal system. For example, beginning in 1971, the Maine Supreme Judicial Court, sitting as the Law Court, held that a *habeas corpus* petitioner, found not guilty of a felony and later involuntarily committed to a mental institution without a separate hearing, was not denied due process or equal protection of the law.<sup>77</sup> In 1979, the court held that the fact that a defendant was recently civilly committed to a mental hospital does not, by itself, raise a reasonable doubt as to culpability without additional evidence.<sup>78</sup> The court later held that an “irresistible impulse,” or an

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67. *Id.*

68. CRIMINAL RESOURCE MANUAL § 634, <http://www.justice.gov/usam/criminal-resource-manual-634-insanity-defense-reform-act-1984> (last visited Sept. 2, 2016).

69. 24 JAMES WM. MOORE ET AL., MOORE’S FEDERAL PRACTICE, § 612.2 (3d ed. 2015) (explaining that the DC Circuit and the ALI adopted a new insanity test in response to growing criticisms of existing tests).

70. The ALI proposed a new insanity test, which stated: “(1) A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law. (2) As used in this article, the terms “mental disease or defect” do not include an abnormality manifested only by repeated criminal or otherwise anti-social conduct.” *Id.*

71. *Id.*

72. *See Id.*

73. Firestone, *supra* note 60.

74. CRIMINAL RESOURCE MANUAL § 634, <http://www.justice.gov/usam/criminal-resource-manual-634-insanity-defense-reform-act-1984> (last visited Sept. 2, 2016).

75. *Id.*

76. For example, in 2006, the Supreme Court upheld a state law narrowing the M’Naughten test for insanity, holding that eliminating part of the federal test did not violate some “constitutional minimum.” *Clark v. Arizona*, 548 U.S. 735, 753 (2006).

77. *Chase v. Kearns*, 278 A.2d 132, 134, 138 (Me. 1971).

78. *State v. Sommer*, 409 A.2d 666, 669 (Me. 1979).

“inability to control one’s actions” does not negate culpability in a criminal trial, but it does serve as an excuse.<sup>79</sup> Finally, in 1985, the court held that evidence with a tendency to negate a defendant’s culpable state of mind should not be excluded when the evidence meets requirements for admissibility noted in *Flick*.<sup>80</sup>

Historically, the Law Court has referred to defenses of mental disease or illness under a catch-all term of “defense of insanity,” without distinction between the types of defenses.<sup>81</sup> The court has also held that a defense of insanity is an affirmative defense,<sup>82</sup> which requires the defendant to prove he lacked culpability by a preponderance of the evidence.<sup>83</sup> Recently, the court has held that a defendant may raise both a mental abnormality defense and an insanity defense.<sup>84</sup> When a defendant raises a mental abnormality defense, the burden does not shift to the defendant, but rather remains on the prosecution to prove culpability beyond a reasonable doubt.<sup>85</sup> An abnormal condition of the mind of a specific character, which “substantially affects cognitive or substantially impairs volitional processes,” may result in a verdict of not guilty by reason of insanity.<sup>86</sup> Conversely, an abnormal condition of the mind defense may result in an acquittal if it successfully raises reasonable doubt as to culpability.<sup>87</sup>

Common law in Maine typically prohibits a jury instruction regarding a “not criminally responsible by reason of insanity” verdict.<sup>88</sup> This is largely founded in the reasoning that Maine juries serve only a fact-finding function, and the legal consequences of their fact-finding should be immaterial to the jury’s deliberations.<sup>89</sup> However, other state courts are split on the issue.<sup>90</sup> More than twenty state jurisdictions allow jury instructions on the consequences of an insanity verdict, deciding that common misconceptions regarding such a verdict may prevent the jury from finding that verdict.<sup>91</sup> Jurors may be reluctant to find the defendant not criminally responsible by reason of insanity because they do not want the defendant to “go free.”<sup>92</sup>

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79. *State v. Mishne*, 427 A.2d 450, 455 (Me. 1981).

80. *State v. Murphy*, 496 A.2d 623, 631 (Me. 1985) (referencing the rule decided by the Law Court in *State v. Flick*, that an expert witness may not give opinions of whether the defendant acted intentionally or knowingly during the crime, as such testimony contains “legal conclusions beyond the specialized knowledge of the expert.” 425 A.2d 167, 171 (1981)).

81. *State v. Howard*, 405 A.2d 206, 211 (Me. 1979).

82. An “affirmative defense” is a defense where the defendant maintains, “even if I did it, I’m not responsible.” 24 Moore’s Federal Practice, § 612.2 (Matthew Bender 3d ed. 2015).

83. *State v. Burnham*, 406 A.2d 889, 891-92 (Me. 1979).

84. *State v. Graham*, 2015 ME 35, ¶ 22, 113 A.3d 1102.

85. *Id.* ¶ 17 (quoting *State v. Likay*, 458 A.2d 427, 428 (Me. 1983)).

86. 418 A.2d 1108, 1117 (Me. 1980).

87. *Id.*

88. “It has long been the settled practice in our State that the function of the jury is to find the facts and to apply the law as given by the court to the facts in reaching their verdict. Punishment, or whatever may transpire after the verdict, is not the concern of the jury.” Christopher J. Rauscher, Note, “*I Did Not Want a Mad Dog Released*” – *The Results of Imperfect Ignorance: Lack of Jury Instructions Regarding the Consequences of an Insanity Verdict in State v. Okie*, 63 ME. L. REV. 593, 596 (2011) (quoting *State v. Park*, 159 Me. 328, 336, 193 A.2d 1, 5 (1963)).

89. *Id.* at 594 (quoting *State v. Okie*, 2010 ME 6, ¶ 11, 987 A.2d 495).

90. *Id.* at 594.

91. *Id.* at 595.

92. *Id.*

In reality, Maine is a “mandated commitment” jurisdiction. When there is a “not guilty by reason of insanity” verdict, the defendant is mandatorily committed to the custody of the Commissioner of Health and Human Services.<sup>93</sup> Under Maine law, the patient is not eligible for release or discharge until the head of the institution where the patient is placed states in his or her annual report to the Commissioner that it is likely that the patient will not harm someone when released from custody.<sup>94</sup> If the patient has committed a murder under Maine law, the report must also dictate terms for supervision upon release.<sup>95</sup> The Commissioner shall file the report with the Superior Court of the county where the patient is committed, and the court shall review it.<sup>96</sup> If it appears by the report that the patient may be ready for release or discharge, the court shall hold a hearing to determine the appropriateness of the release or discharge.<sup>97</sup> If release is ordered, terms for release are set by the court, and release may be revoked if the person fails to comply with the terms.<sup>98</sup> If discharge is ordered, that person still remains in custody of the Commissioner, and the discharge is subject to annual review by the court, or by request of the Commissioner, until the court terminates the review.<sup>99</sup>

Lastly, it is helpful to note that Maine makes a careful distinction between challenges to a defendant’s competency to stand trial and a defendant making an insanity defense.<sup>100</sup> Both types of challenges consist of “abnormal mental states,” but they are distinct and separate issues.<sup>101</sup> For example, a defense of insanity concerns the mental state of the defendant only when the crime was committed.<sup>102</sup> If the issue proceeds to trial, the question for the factfinder is whether the defendant was criminally responsible for committing the crime, considering his mental condition at the time.<sup>103</sup> Conversely, a challenge to the defendant’s competency involves consideration of the defendant’s mental state during the prosecution prior to and during the trial.<sup>104</sup>

The “constitutional standard” for the threshold of competence is “whether the defendant . . . has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and has a ‘rational as well as factual understanding of the proceedings against him.’”<sup>105</sup> The process to determine the competency of a defendant is laid out in 18 U.S.C. § 4241.<sup>106</sup> The process is as follows: “(1) the motion to order a competency hearing; (2) the defendant’s

93. *Id.* at 598.

94. 15 M.R.S. §104-A(1) (2015).

95. *Id.*

96. *Id.*

97. *Id.*

98. *Id.* § 104-A(1)(A)(1), (2).

99. *Id.* § 104-A(1)(B).

100. 1-5 Pretrial Motions in Criminal Prosecutions § 5-8 (2015). The distinction is important because “[t]he government denies the defendant his due process right to a fair trial when it convicts an incompetent defendant or fails to provide adequate procedures for determining competence . . . [T]here can be no trial or further proceedings if the defendant is incompetent.”

101. *Id.*

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.* (citing 18 U.S.C. § 4241(a) (2006)).

106. *Id.*

examination by experts on the issue of competence; and (3) the competency hearing before the judge.”<sup>107</sup>

Issues of competency may be raised at any time during pretrial proceedings or trial proceedings, and are often raised more than once during proceedings.<sup>108</sup> Either the prosecution or the defense may make a motion to determine competency.<sup>109</sup> Defense counsel may be obligated by fiduciary and professional duty to move to determine competency, whether or not the client wishes to make the motion.<sup>110</sup> A court may also decide *sua sponte* to hold a competency hearing to determine the competency of the defendant at any point during proceedings.<sup>111</sup> A court is required to do so if there is “reasonable cause” to believe that the defendant is currently suffering from a “mental disease or defect” which may render the defendant unable to comprehend the proceeding against him, or assist in preparing a complete defense.<sup>112</sup> It is also important to note that the standard of review for “reasonable cause” is a low threshold.<sup>113</sup>

If a court finds reasonable cause to hold a competency hearing, 18 U.S.C. § 4241(b) authorizes the court to compel an examination of the defendant, with a written report prepared by a licensed psychiatrist or psychologist.<sup>114</sup> During this period of evaluation, the defendant may be ordered by the court to be temporarily committed for a reasonable amount of time, but not longer than thirty days.<sup>115</sup> The report of the facility is later delivered to the court.<sup>116</sup>

## 2. Guardianship in Maine

Prior to the passage of the Act, Maine law allowed an incapacitated person in Maine to have a guardian appointed on his or her behalf.<sup>117</sup> The process of the appointment of guardianship is as follows:<sup>118</sup> a court determines whether a person

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107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.* It is worth noting that it is not only the responsibility of defense counsel to ensure a fair trial. See *State v. Dolloff*, 2012 ME 130, ¶ 41, 58 A.3d 1032 (“A prosecutor is, however, imbued with a special responsibility in representing the State and ‘has a responsibility to help ensure a fair trial.’”) (quoting *State v. Lockhart*, 2003 ME 108, ¶ 48, 830 A.2d 433). However, this discussion is beyond the scope of this Comment.

111. 1-5 Pretrial Motions in Criminal Prosecutions, *supra* note 100.

112. *Id.*

113. *Id.* Case law indicates that courts most often find reasonable cause when the court has access to detailed information of the specific defendant, including information about the defendant’s behavior and demeanor during the litigation and proceedings, and a detailed mental health history of the defendant. *Id.*

114. *Id.* The court may appoint more than one licensed psychiatrist or psychologist, if deemed necessary and appropriate. *Id.*

115. *Id.* The director of the hospital or center where the defendant is committed may request an extension of time, upon a showing of “good cause” that the facility needs more time to evaluate and examine the defendant. *Id.* Extension of time must be reasonable, and may not exceed more than fifteen days. *Id.*

116. *Id.* However, the facility’s findings, observations, and directions within the report are not binding upon the court. *Id.*

117. 22 M.R.S. § 3482 (1981).

118. See MAINE’S GUARDIANSHIP/CONSERVATORSHIP: QUESTIONS AND ANSWERS GUIDE, <http://www.maine.gov/dhhs/oads/aps-guardianship/guardianship.html> (last visited Sept. 8, 2016).

meets the legal definition of “incapacitated,”<sup>119</sup> which then requires appointment<sup>120</sup> of a guardian.<sup>121</sup> A guardian appointed by a court makes decisions on behalf of the incapacitated person lacking decision-making capacity, also called a “ward,”<sup>122</sup> and may have either limited or unlimited powers.<sup>123</sup> A guardian may also be appointed temporarily, possibly without a hearing, for a period of no more than six months.<sup>124</sup> Unlimited powers allow the guardian to make decisions about the patient’s treatment over the patient’s objections, whereas a guardian with limited powers can make treatment decisions only if specifically authorized by guardianship papers.<sup>125</sup> A guardian is limited by the advanced directives for care that the patient gave when competent, and may only contradict the directives with the approval of the court.<sup>126</sup>

A guardian may be public or private; a public guardian is a state agency, while a private guardianship consists of everything else.<sup>127</sup> Additionally, there is a particular order of preference given to certain individuals for the appointment of guardianship.<sup>128</sup> Guidelines for the Riverview Psychiatric Recovery Center, where defendant Leroy Smith III was admitted, provide that a patient has the right to appoint representatives to make decisions on his or her behalf, whereas guardians are authorized to make decisions without the patient’s consent.<sup>129</sup> There are also

119. “‘Incapacitated adult’ means any adult who is impaired by reason of mental illness, mental deficiency, physical illness or disability to the extent that the individual lacks sufficient understanding or capacity to make or communicate responsible decisions concerning that individual’s person, or to the extent the adult cannot effectively manage or apply that individual’s estate to necessary ends.” 22 M.R.S.A. § 3472(10) (2015).

120. The standard of proof for a finding which approves a guardian for an incapacitated person is now “clear and convincing,” a recent change from the “preponderance of the evidence” standard previously utilized by the State. *See In re Anthony R.*, 2010 ME 4, ¶¶ 10, 11, 987 A.2d 532.

121. A court may also appoint a conservator, which is an appointed individual, corporation, or agency appointed to “protect and manage” the assets of the incapacitated person unable to manage his or her own estate. However, this is beyond the scope of this Comment. MAINE’S GUARDIANSHIP/CONSERVATORSHIP: QUESTIONS AND ANSWERS GUIDE, *supra* note 118.

122. *Id.*

123. *Id.*

124. A temporary guardian may have the same responsibilities and powers of a permanent guardian. If the incapacitated adult ward wishes to contest the appointment, the court will hold an “expedited hearing” within 40 days. *Id.*

125. *Id.*

126. *Id.*

127. *Id.*

128. *Id.* (The order of preference for the appointment of a guardian, as established by Maine law, is as follows:

1. The person or organization nominated in writing by the person in need of a guardian;
2. The spouse;
3. The domestic partner;
4. An adult child;
5. A parent, including a person nominated by will or other writing signed by a deceased parent;
6. Any relative with whom the person in need of a guardian has lived with for more than six months prior to the filing of the petition;
7. A person nominated by someone who is caring for the incapacitated person or paying benefits to him or her.)

129. RIVERVIEW FULL RIGHTS OF RECIPIENTS ADULT MANUAL, <http://www.maine.gov/dhhs/samhs/mentalhealth/rights-legal/recipients/RightsRecipients/index.shtml> (last visited Sept. 8, 2016). The responsibilities and powers of a guardian are essentially the same as a

several other psychiatric centers in the State of Maine, in addition to the Riverview Psychiatric Recovery Center.

### 3. *Process of Medical Treatment in Maine*

Psychiatric hospitals in Maine have a unified procedure for involuntarily medicating psychiatric patients, which predates the Act.<sup>130</sup> The procedure provides that hospital patients have a right to “informed consent,” so patients with capacity may refuse medical treatment, except in a case of “emergency.”<sup>131</sup> A patient may only be involuntarily medicated under the following conditions:

- a guardian for the incapacitated patient consents,
- the incapacitated patient has an advance directive that allows treatment over objection,
- a District Court has ordered treatment with an involuntary commitment,
- treatment is authorized following a clinical review panel,
- treatment is authorized following an administrative hearing, or
- a psychiatric emergency exists.<sup>132</sup>

It is worthwhile to discuss each of these conditions in turn. First, as previously discussed, a court may appoint a guardian to a patient as necessary.<sup>133</sup> Whether the guardian is appointed limited or unlimited powers affects whether the guardian may consent to medication of the patient; however, despite the categorization of the guardian, the guardian may not consent to restraint of the patient to administer the medication.<sup>134</sup> A guardian’s power is also restricted by the patient’s health care directive and power of attorney, and the guardian may not contradict the patient’s instructions given at time of capacity.<sup>135</sup>

Second, an agent, power of attorney, or guardian of a patient must follow instructions the patient gave when he retained decisional capacity.<sup>136</sup> These instructions, either oral or written, may be given by the patient, either to his physician or health care provider, or to a surrogate.<sup>137</sup> A surrogate is a person able to make decisions on behalf of the patient if no guardian or agent is “reasonably available.”<sup>138</sup> Persons who may act as surrogates include “spouses, life partners, adult children, [and] parents.”<sup>139</sup>

Third, a Maine District Court may order involuntary treatment of a committed

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parent’s responsibilities and powers toward a minor child. For a more expansive discussion, see MAINE’S GUARDIANSHIP/CONSERVATORSHIP: QUESTIONS AND ANSWERS GUIDE, *supra* note 118.

130. ME. DEPT. OF HEALTH AND HUMAN SERVICES, MEDICATING PATIENTS INVOLUNTARILY AT PSYCHIATRIC HOSPITALS (Dec. 31, 2013), [http://maine.gov/dhhs/samhs/mentalhealth/rights-legal/involuntary/Medicating\\_Patients.html](http://maine.gov/dhhs/samhs/mentalhealth/rights-legal/involuntary/Medicating_Patients.html).

131. *Id.* at 1.

132. *Id.*

133. *Id.*

134. *Id.*

135. *Id.*

136. *Id.* at 2.

137. *Id.*

138. *Id.*

139. *Id.*



patient.<sup>140</sup> However, the treatment may only last up to 120 days or until the end of the patient's commitment, whichever may occur first, and there must be a commitment hearing to ensure that certain guidelines are met.<sup>141</sup> The guidelines for such a court order essentially follow the *Sell* factors:

[T]he court must find that the patient is incapacitated, the patient is unwilling or unable to comply with recommended treatment, the need for treatment outweighs risks and side effects, and the recommended treatment is the least intrusive appropriate option. The court findings may also include findings that the failure to treat the illness is likely to produce great harm to the person, or that without the treatment, the person's commitment will likely be significantly extended without addressing the symptoms that pose a likelihood of serious harm.<sup>142</sup>

Fourth, treatment may be permitted following a meeting of a Clinical Review Panel, which is the "exclusive administrative process for authorization of involuntary medication for civilly committed patients."<sup>143</sup> To initiate a meeting of a Clinical Review Panel, the patient's physician must request the meeting.<sup>144</sup> Then, the hospital head "appoints a panel of at least two licensed professional staff," one of which must be licensed to prescribe medication.<sup>145</sup> The panel may not include any of the patient's direct care providers.<sup>146</sup> During the meeting, the patient and an advocate may be present to discuss the refusal of treatment, inform the panel or present witnesses, and to ask questions to the panel.<sup>147</sup> The panel is restricted to the same *Sell*-like guidelines as the court order above, and the same 120-days-or-until-end-of-the-involuntary-commitment timeline for extent of treatment as above.<sup>148</sup>

Fifth, the procedure includes "Rights of Recipients of Mental Health Services," which provide for an involuntary medication administrative hearing process, but is only available for forensic patients such as Leroy Smith III.<sup>149</sup> This administrative hearing process is initiated by a mental health professional, generally a psychiatrist, recommending a specific treatment for the forensic patient.<sup>150</sup> If the patient refuses or objects to the treatment, the professional determines whether the patient has capacity to object to the treatment; if the professional determines that the patient does not, the professional must obtain a second opinion.<sup>151</sup> If the second opinion concurs, the professional must notify the Disability Rights Center, often the patient's next of kin, an agent or advocate of the patient if the patient has one, and the hospital head.<sup>152</sup> Before the hearing for involuntary treatment is initiated, there must be an alternative treatment meeting held by the professional recommending the treatment.<sup>153</sup> At the

140. *Id.*

141. *Id.*

142. *Id.*

143. *Id.* at 3.

144. *Id.*

145. *Id.*

146. *Id.*

147. *Id.*

148. *Id.*

149. *Id.*

150. *Id.*

151. *Id.*

152. *Id.*

153. *Id.* at 4.

meeting, the patient and the patient's treatment team discuss alternative treatments and the patient's objections.<sup>154</sup> If no alternative is agreed upon, either the professional or the patient may decide whether to proceed to the administrative hearing.<sup>155</sup> The hospital must notify the patient of the requested hearing and his rights, and must assist the patient in obtaining a lawyer.<sup>156</sup> At the confidential hearing, the hospital must show, by clear and convincing evidence, the following:

1. The patient lacks capacity to make a decision about a particular treatment;
2. The proposed treatment is based on adequately substantiated exercise of professional judgment;
3. The benefits of the treatment outweigh the risks and the possible side-effects; and
4. The proposed treatment is the least intrusive appropriate treatment available under the circumstances.<sup>157</sup>

After the hearing, if the hospital established the above elements, there are restrictions on the treatment that may be ordered.<sup>158</sup>

Lastly, a patient may be forcibly treated in a period of emergency.<sup>159</sup> An "emergency" situation is limited to the following:

1. As a result of a patient's behavior due to mental illness, there exists a risk of imminent bodily injury to the patient or to others;
2. Treatment is required immediately to ensure the physical safety of the recipient or others;
3. Nobody legally entitled to consent on the patient's behalf is available; and
4. A reasonable person concerned for the physical safety of the patient or others would consent to treatment under the circumstances.<sup>160</sup>

The decision to medicate in an emergency is serious and must not be taken lightly. Emergency treatment cannot be ordered just because a patient refuses or objects to treatment.<sup>161</sup> The patient may only be treated while the emergency persists, and must end if there is no risk of imminent bodily injury.<sup>162</sup> Additionally, the professional ordering the emergency treatment must make the following additional documentations:

- the period (up to seventy-two hours) for which medication may be administered,
- the expected benefits of the emergency treatment order,
- what behaviors and responses the staff should monitor, and

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154. *Id.*

155. *Id.*

156. *Id.*

157. *Id.*

158. For example, if the patient shows that he would have refused the treatment, if he had capacity, on religious grounds or personal beliefs, treatment will not be authorized. Further restrictions dictate that electroconvulsive therapy may not be ordered, the hospital must wait to begin treatment at least a full day after the order, and if the hospital wants to continue treatment after the 60-day period, it must go through the same process as the original hearing and also notify the patient's family or public guardian of the possible need for guardianship. The patient may appeal the order. *Id.*

159. *Id.* at 4-5.

160. *Id.*

161. *Id.*

162. *Id.*

- how the staff should monitor the patient's behaviors and response to treatment.<sup>163</sup>

The State of Maine has these described procedures in place to administer treatment of patients in the state's psychiatric hospitals. The procedures have built-in limitations and short-term restrictions on medication to deal with the issue of safety regarding the patient. The Act expanded the existing procedure to force treatment and medication upon a defendant in the pretrial posture for the purpose of possibly restoring competency to stand trial, regardless of whether the defendant poses current safety concerns to himself or others.

## V. MORALITY OF INVOLUNTARY MEDICATION

*"The right of a person to control his own body  
is a basic societal concept,  
long recognized in the common law . . . ."*  
—Judge Sidney M. Schreiber<sup>164</sup>

### A. Deprivation of Fundamental Rights

As previously discussed, the American criminal justice system has been built around notions of fundamental fairness in every criminal trial. These notions include the fundamental right to a fair and accurate trial, and the fundamental right to aid in the presentation of one's own defense.<sup>165</sup> The forced medication of a pretrial defendant is contrary to these notions of fairness because it inhibits the defendant's ability to communicate with his attorney in the preparation and presentation of his own defense, and affects the way the defendant is perceived at trial.<sup>166</sup>

Furthermore, a defendant who is under the influence of antipsychotic medication, and thus subject to its side effects, may be (1) prejudiced by the way his behavior in court is perceived by the fact finder, and (2) prejudiced by his own inability to assist in the preparation of his defense before trial.<sup>167</sup>

### B. Lack of Legitimate Penological Purpose

Additionally, although the Constitution does not require laws to serve one specific penological interest, there are four traditional legitimate goals of penal sanctions: incapacitation, rehabilitation, deterrence, and retribution.<sup>168</sup> Forcible medication for the sole purpose of rendering the defendant competent to stand trial only serves one goal – retribution.

"Incapacitation" is described as the concept that society is protected by removing a criminal from society because that criminal cannot commit further

163. *Id.*

164. *In re Conroy*, 486 A.2d 1209, 1221 (N.J. 1985).

165. Firestone, *supra* note 60, at 621 ("Society's sense of morality dictates that an individual who is unable to comprehend the nature and the object of the proceedings against him or her, to confer with counsel, and to assist in the preparation of his or her own defense may not be subjected to a criminal trial.")

166. *See infra* Part VI.

167. *See infra* Part V, Section B.

168. *See Ewing v. California*, 538 U.S. 11, 25 (2003).

crimes.<sup>169</sup> “Rehabilitation” is the idea that sanctions are imposed to rehabilitate the criminal so that he will no longer commit crimes if he is reintroduced into society.<sup>170</sup> “Deterrence” is typically described as the concept that penal sanctions deter that criminal from engaging in the same conduct again.<sup>171</sup> Lastly, “retribution”—the “oldest form of punishment”—is the idea that punishment is necessary to retaliate against the defendant, get revenge for the wrong committed, and serve upon the defendant his “just deserts.”<sup>172</sup>

A defendant such as Leroy Smith III, who is already in custody of the state as a patient in a mental facility, is already incapacitated. Similar to a prisoner, a defendant who is a patient at such a facility is removed from society and unable to commit further crimes. Additionally, the patient is already in a rehabilitative environment. The patient has around-the-clock care to meet that patient’s needs and is in a safe environment. As for deterrence, it is unlikely that such a goal can be readily met with a defendant like Smith. When the defendant has been deemed incompetent to stand trial, it is unlikely that any sanction will have a deterrent effect for that defendant, because the defendant most likely does not comprehend the implications of the sanction. Therefore, imposing a sanction on a criminal defendant who has been deemed incompetent, is already incapacitated, and is in a rehabilitative environment can only serve the penological interest of retribution.

By seeking to forcibly medicate a defendant for the sole purpose of rendering the defendant competent for trial, the State is seeking an opportunity to retaliate against the defendant—the defendant who is presumed innocent in the pretrial stage. The State is seeking to ignore the current incapacitation of the defendant in a rehabilitative environment, and is instead attempting to subject the defendant to trial for the sole purpose of retaliating against him for his crimes. This is morally reprehensible conduct by the State. The most likely outcomes are that the defendant is found not criminally responsible by reason of insanity at the trial, and then the defendant will end up back in the facility he was first located in, or that the defendant is found guilty of his crimes, and given a prison sentence that is likely to be far less rehabilitative than treatment in a mental hospital. Some may argue that “just deserts” require a defendant to spend adequate time receiving a punishment for his actions. However, a defendant could actually spend more time as a patient in a mental hospital than as an inmate in prison.<sup>173</sup>

#### VI. THE *SELL* FACTORS

*“The only part of the conduct of any one,  
for which he is amenable to society,  
is that which concerns others.”*

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169. 1 WAYNE R. LAFAVE, SUBSTANTIVE CRIMINAL LAW § 1.5, Westlaw (2d ed., database updated Oct. 2015).

170. *Id.*

171. *Id.*

172. *Id.*

173. *See Foucha v. Louisiana*, 504 U.S. 71, 76 n.4 (2010) (explaining that a defendant who is found not guilty by reason of insanity may be held until he is no longer mentally ill or no longer a threat to his own safety or the safety of others; the length of time which a patient “may be held in a mental institution is not measured by the length of a sentence that might have been imposed had he been convicted . . .”).

*In the part which merely concerns himself,  
his independence is, of right, absolute.  
Over himself, over his own body and mind,  
the individual is sovereign.”*  
—John Stuart Mill<sup>174</sup>

The factors provided by the United States Supreme Court in *Sell v. United States*<sup>175</sup> establish the constitutionality of involuntary medication to restore competence to stand trial. However, each factor is intentionally stringent. It is especially difficult to satisfy these requirements in the State of Maine, due to the policies and procedures discussed above. To further illustrate this issue, each *Sell* factor will be discussed in turn.

*A. Whether Treatment is Medically Appropriate*

*“No right is held more sacred, or is more carefully guarded,  
by the common law, than the right of every individual  
to the possession and control of his own person,  
free from all restraint or interference of others,  
unless by clear and unquestionable authority of law.”*  
—Justice Horace Gray<sup>176</sup>

The first requirement the Supreme Court established in *Sell* is that the court must determine whether the treatment of the defendant is “medically appropriate.”<sup>177</sup> Historically, involuntary treatment with antipsychotic drugs was deemed “medically appropriate” when used for the purpose of reducing the risk of danger to the patient and to others.<sup>178</sup> Typically in Maine, treatment of incapacitated patients has been considered medically appropriate when the purpose behind the treatment is to protect the patient from harming himself or others.<sup>179</sup> As such, the Law Court has determined that personal autonomy to refuse medical treatment is “not absolute and does not operate to prevent the State from acting to protect her from doing harm to herself and others.”<sup>180</sup> This was a limitation imposed on rules established in *In re*

174. JOHN STUART MILL, ON LIBERTY 17 (2011) (ebook).

175. *Sell v. United States*, 539 U.S. 166, 179 (2003).

176. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

177. *Sell*, 539 U.S. at 179.

178. See generally *Washington v. Harper*, 494 U.S. 210, 228 (1990) (holding that the state has a “legitimate interest in treating [a prisoner] where medically appropriate for the purpose of reducing danger he poses.”); see also *Riggins v. Nevada*, 504 U.S. 127, 135 (1992) (holding that the administration of antipsychotic drugs to the defendant *during* trial would not have violated due process if the court had found, among other things, that the treatment was “essential for the sake of [defendant’s] own safety or the safety of others.”).

179. See generally *Guardianship of Boyle*, 674 A.2d 912 (Me. 1996) (Law Court upheld the power of the Department of Human Services, as an appointed guardian with limited powers for the incapacitated patient, to authorize treatment with psychotropic medication, even though patient had expressed contrary wishes before she was determined to be incapacitated).

180. *Id.* at 914.

*Gardner*<sup>181</sup> and *In re Swan*.<sup>182</sup> Maine in the past has determined that the law of informed consent encompasses the right to refuse medical treatment, in part based on the “patient’s right to be free from nonconsensual invasions of his bodily integrity.”<sup>183</sup> Additionally, the court has acknowledged that medication may affect a defendant’s ability to participate in the legal process.<sup>184</sup>

The case of Leroy Smith III will again be utilized to exemplify these principles in practice. Smith has consistently refused treatment suggested to him by the state forensic hospital, Riverview Psychiatric Center.<sup>185</sup> Miriam Davidson, a nurse practitioner at Riverview who is assigned to Smith’s team, stated that if the involuntary medication of Smith is approved by the court, the hospital would start Smith on Zyprexa.<sup>186</sup> The hospital would like a regimen of antipsychotic medication—it is not clear whether the regimen is to consist entirely of Zyprexa, or if other medications will be administered as well—to be ordered for a six-month time period, with the option of early evaluation if it appears that Smith’s competency is restored, or appears restored, earlier than expected.<sup>187</sup> The hospital has already administered Zyprexa to Smith, during a recent “psychiatric emergency” in November, when Smith was “presenting a danger to others” while he resisted hospital personnel attempting to administer his antipsychotic medication.<sup>188</sup> Davidson revealed that, during this episode, Smith was restrained and the medication forcibly administered by injection.<sup>189</sup> Davidson further explained that the medication would first be offered to Smith as an oral dose, but if again refused, the medication would be administered as a forcible injection.<sup>190</sup> Current hospital policies allow such an involuntary administration of medication until the patient is no longer considered to be dangerous, but no longer than seventy-two hours.<sup>191</sup>

In the case of Smith, use of Zyprexa has been determined by Riverview to be medically appropriate, at least to treat his dangerous conduct. However, it has been used on Smith only for short periods of time, up to only seventy-two hours, as

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181. 534 A.2d 947, 951 (Me. 1987) (holding that the common law doctrine of informed consent governs the right to refuse treatment, including life-sustaining treatment, and the right of informed consent is without significance if the right does not also include the right to *informed refusal*).

182. 569 A.2d 1202, 1205 (Me. 1990) (affirming the Superior Court’s order to allow discontinuance of life-sustaining procedures, after a determination that sufficient evidence existed that patient had made decision before the procedures were necessary that he did not want to be kept alive in a vegetative state by life-sustaining procedures, regardless of the fact that such declarations were made before the patient had reached the age of majority).

183. *Gardner*, 534 A.2d at 951.

184. *In re Christopher H.*, 2011 ME 13, ¶ 19, 12 A.3d 64 (holding that when a court learns that an individual who is the subject of an involuntary commitment hearing has been involuntarily medicated, “it will suffice if the record reflects that the court asked the individual, his or her attorney, or an expert medical witness to discuss whether and to what extent the effects of the medications involuntarily administered to the individual interfere with the individual’s ability to be present and participate in the hearing.”).

185. Adams, *supra* note 2, at 6.

186. *Id.* at 2.

187. *Id.*

188. *Id.*

189. *Id.*

190. *Id.*

191. *Id.*

directed by hospital policy. Treatment of a defendant awaiting trial will necessarily be longer than seventy-two hours, because far more time is necessarily needed to prepare the defense and go through the necessary pretrial motions and proceedings.<sup>192</sup> The mere fact that a certain medication has been declared appropriate to treat the specific short-term behavior of the defendant does not mean that the medication is appropriate to treat the long-term behavior of the defendant. If the specified drug, in Smith's case Zyprexa, begins to fail and is no longer successful in treating the defendant, a different drug will most likely be administered as part of the treatment regimen. This could mean that the defendant will now be treated with antipsychotic medication that he has never been treated with before, which may carry different or additional side effects. The hospital may not know how the defendant will respond to it and what reactions it will incite from the defendant.

Additionally, Miriam Davidson, the psychiatric nurse practitioner treating Smith, said in court that the medical treatment will not prevent Smith from experiencing his delusions; it will only help him manage them better.<sup>193</sup> Davidson also said that many people suffering from delusional disorder may never experience a complete end to their delusions.<sup>194</sup> Lastly, Davidson explained that delusional disorder, which she diagnosed Smith with, does not respond to medical treatment as well as other disorders.<sup>195</sup> These statements further illustrate why deeming forcible drug treatment "medically appropriate" is problematic. In addition to being unable to know how the drugs might affect the defendant on a long-term basis, some disorders are more difficult to treat than others. As is true for most mental health diagnoses, the patient may never truly be rid of the effects of his disorder.

Lastly, a major concern in determining whether treatment of the defendant is "medically appropriate" is the amount of reliance necessarily involved between the legal and medical profession. Specifically, judges typically lack specialized medical training.<sup>196</sup> This poses two distinct issues. First, because a hearing concerning whether or not to forcibly medicate a defendant necessarily includes a discussion of which medication to treat with and the specifics of the dosage, this can involve a court making medical decisions without medical training, essentially "practicing medicine from the bench."<sup>197</sup> Perhaps even worse, a court could order medical

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192. In United States District Courts, the average length of time for a homicide offense, from filing to completion of jury trial, is 16.9 months. U.S. DISTRICT COURTS – MEDIAN TIME FROM COMMENCEMENT TO TERMINATION FOR CRIMINAL DEFENDANTS, BY OFFENSE, Table D-10, [http://www.uscourts.gov/statistics-reports/caseload-statistics-data-tables?tn=&pn=All&t=69&m\[value\]=\[month\]=&y\[value\]=\[year\]](http://www.uscourts.gov/statistics-reports/caseload-statistics-data-tables?tn=&pn=All&t=69&m[value]=[month]=&y[value]=[year]) (last visited April 25, 2016).

193. Brogan, *supra* note 3.

194. *Id.*

195. *Id.*

196. Richart L. DeMier & Robert G. Sarrazin, *The Sell Decision: An Argument for Judicial Restraint*, 37 J. PSYCHIATRY & L. 335, 336 (2009).

197. *Id.*; see also Hon. Jessie B. Gunther, *Reflections on the Challenging Proliferation of Mental Health Issues in the District Court and the Need for Judicial Education*, 57 ME. L. REV. 541, 542 (2005). Judge Gunther said:

Maine's courts constantly deal with litigants with mental health issues. Historically, our decisions have relied on expert testimony addressing specific issues of responsibility, risk, and treatment. In recent years, by my observation, court involvement in the treatment process has increased, but the availability of expert evidence has decreased. Thus, we as judges have become the ultimate decision-makers regarding litigants'

treatment of a defendant without identification of specific medication and dosage. This would allow hospital, prison, or jail staff (wherever the defendant may be presently located) “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.”<sup>198</sup>

Second, if the court is conscious about avoiding the practice of bench-medicine, it will likely heavily rely on the findings and determinations of witnesses, likely medical personnel involved with the treatment of the patient. The problem with this scenario is that the medical personnel who are influencing the court’s order are unlikely to be trained in the legal profession, so they are unlikely to know the legal consequences of their findings and determinations that they present to the court. They are likely to focus only on how the treatment will affect the defendant, instead of considering the entire picture of what the forcible medical treatment means for the defendant. Neither of these possibilities are particularly encouraging for a pretrial defendant: either a court is making an uninformed and possibly dangerous determination of specific medication and dosage, or a medically trained health professional is making a decision about treatment without understanding the legal consequences of that treatment. In reality, there is no safeguard to prevent either scenario,<sup>199</sup> and it is hard to determine which is more threatening.

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mental health treatment in both criminal and civil contexts, without supporting expert testimony. In the face of this development, three interconnected issues arise.

*Id.*

198. DeMier & Sarrazin, *supra* note 196, at 336 (quoting *United States v. Evans*, 404 F.3d 227, 241 (4th Cir. 2005)). Additionally, Judge Gunther explained that the decision-making authority of judges in Maine regarding mental health issues is problematic for three reasons. First, because judicial involvement with mental health treatment has increased, but the availability of experts for mental health issues have decreased, there is an issue of “whether judges should even attempt to fill the void caused by lack of expert testimony.” Judges in Maine receive a type of “on-the-job training,” whereby after listening to enough experts discuss mental health issues, the Judge receives a technical education of the issues. However, by default, judges in Maine are forced to use their own training and expertise—or lack thereof—to fill the gap. This is especially problematic because areas of the law are always changing, and relying on the judge’s “on-the-job training” is dangerous because it does not “ensure that their education is of the highest quality and derived from the latest data. The second issue Judge Gunther addresses is whether the standards to “achieve competency” in the field of mental health—i.e. become an expert—should be altered, to meet the “essential” need for experts in certain areas of the law. The third and final issue Judge Gunther addresses is the lack of feedback for sentencing and treatment of defendants with mental health issues, and the need for “measuring the efficacy of judicial intervention,” and determining whether sentencing and treatment of defendants with mental health issues is working. As a solution, Judge Gunther posits “common education” for judges in Maine. The education should include training about mental disorders, substance abuse and mental health, the sufficiency of “alternative treatment programs and mental health intervention,” among other issues. There should be a committee of sorts to ensure the judicial education is updated frequently to reflect changes in the profession and in the law, the judicial education should be made available to litigants, and judges should be familiar with which professionals qualify as experts in given areas. Gunther, *supra* note 197, at 142-51.

199. DeMier & Sarrazin, *supra* note 196, at 336-37 (“Only a strict interpretation of *Sell*, however, should lead a court to conclude that such specificity is necessary. In fact, if the goal of the proceeding is to facilitate restoration of competency, such a conservative course could delay, if not derail, the competency restoration process.”).



*B. Side Effects of Treatment and Fairness of Trial*

“The right to one's person  
may be said to be a right of complete immunity:  
to be let alone”

—Judge Thomas M. Cooley<sup>200</sup>

The second *Sell* factor requires a court to consider the side effects of the treatment and the fairness of trial before forcibly administering the medication.<sup>201</sup> Due to the significant side effects of antipsychotic medication, involuntary medication to render a defendant competent to stand trial jeopardizes that defendant's right to a fair trial.<sup>202</sup> Psychotropic drugs “deaden the patient's ability to think and their forced administration is an affront to basic concepts of human dignity.”<sup>203</sup> For example, side effects of antipsychotic medication may include “nervous ticks, tremors, spasms, and the need to be in constant motion,” which may occur in over half the patients treated with “conventional antipsychotic drugs.”<sup>204</sup> Some conditions caused by antipsychotic drugs are potentially irreversible.<sup>205</sup> Antipsychotic medication may also produce side effects such as weakness, dizziness, blurred vision, and difficulty concentrating.<sup>206</sup> Even when the drugs are properly prescribed, all antipsychotic drugs may cause “neurological and non-neurological” side effects.<sup>207</sup>

Common non-neurological side effects include sedation, and also:

Orthostatic hypotension, which causes fainting and falling . . . decreased libido in both sexes and impotence in males; peripheral anticholinergic effects such as dry mouth, constipation, urinary retention, nausea, and vomiting; central anticholinergic effects such as agitation, disorientation, hallucinations, seizures, and coma; retinal pigmentation which may result in blindness; agranulocytosis, a potentially fatal blood condition; lethal cardiotoxicity; allergic dermatitis; and weight gain. Many of these effects can be controlled by reducing dosages, adding other medicine, or changing to a different antipsychotic drug. These side effects generally cease when the drugs are discontinued, although chronically ill patients on maintenance doses of antipsychotic drugs may suffer permanent side effects.<sup>208</sup>

Clearly, there are numerous serious non-neurological side effects associated with antipsychotic drugs. An additional problem with such side effects is the

200. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891) (citing Cooley on Torts (2d ed.) 29).

201. *Sell v. United States*, 539 U.S. 166, 179 (2003).

202. See John R. Hayes, *Sell v. United States: Is Competency Enough to Forcibly Medicate a Criminal Defendant?*, 94 J. CRIM. L. & CRIMINOLOGY 657, 657 (2004).

203. *Guardianship of Boyle*, 674 A.2d 912, 918 (Me. 1996) (Lipez, J., dissenting) (citing *Davis v. Hubbard*, 506 F. Supp. 915, 936 (N.D. Ohio 1980)).

204. Hayes, *supra* note 202, at 658 (explaining that “extrapyramidal reactions . . . have been found to occur in fifty to seventy-five percent of patients treated with conventional antipsychotic drugs.”).

205. *Id.* (explaining that “tardive dyskinesia . . . a vicious form of an extrapyramidal reaction . . . is characterized by involuntary and jerky movement of the facial and oral muscles, along with the upper and lower extremities and trunk . . . and is potentially irreversible.”).

206. *Id.*

207. William P. Ziegelmueller, *Sixth Amendment—Due Process on Drugs: The Implications of Forcibly Medicating Pretrial Detainees with Antipsychotic Drugs*, 83 J. CRIM. L. & CRIMINOLOGY 836, 838-39 (1993).

208. *Id.* at 839.

possibility that an incapacitated defendant may be subject to a long trial-and-error process, where different drugs are tested to see which is most suitable for that particular defendant.

In addition to non-neurological side effects, possible neurological side effects may include:

[D]ystonias, parkinsonian symptoms, akathisia, tardive dyskinesia [which is involuntary movements of face and extremities], neuroleptic malignant syndrome, and seizures. Dystonic movements involve muscle spasms in the eyes, neck, face, tongue, and arms. Parkinsonian symptoms include muscle stiffness, stooped posture, a mask-like face, tremors, and drooling. Akathisia is muscular discomfort that causes restlessness and agitation. Both dystonic and parkinsonian effects occur relatively often, although less so when Mellaril is used. Other drugs may be used to treat the symptoms of these side effects until a patient develops a tolerance to the antipsychotic.<sup>209</sup>

The more serious neurological side effects include seizures and the potentially fatal side effect called neuroleptic malignant syndrome, which involves fever and a high pulse, “muscular rigidity,” and altered mental conditions which require immediate cessation of the drugs and medical treatment.<sup>210</sup>

Additionally, antipsychotic drugs considered to be “atypical” come with additional side effects as well, including extrapyramidal effects discussed above, heart arrhythmia, seizures, cataracts, vanishing of white blood cells, and more.<sup>211</sup> Justice Kennedy, in his concurring opinion in *Riggins v. Nevada*,<sup>212</sup> expressed concern about antipsychotic drugs. He maintained that, absent an “extraordinary showing by the state,” Fourteenth Amendment Due Process rights would prohibit involuntary medication for the purpose of restoring competence to stand trial, in most cases, due to the properties of antipsychotic drugs.<sup>213</sup>

Kennedy also suggested that, rather than having their competence restored by involuntary medication, incompetent defendants should be civilly committed.<sup>214</sup> Kennedy warned against the dangers of modern-day antipsychotic medications:

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

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209. *Id.* at 839-40.

210. *Id.* at 840.

211. Hayes, *supra* note 202, at 658-59.

212. 504 U.S. 127, 138-39 (1992) (Kennedy, J., concurring).

213. *Id.*

214. *Id.* at 145. However, federal courts have not upheld indefinite commitment of a defendant, whose likelihood of regaining competency to stand trial is unlikely, based on incompetency alone. *Jackson v. Indiana*, 406 U.S. 715, 733 (1972) (citing *United States v. Curry*, 410 F.2d 1372 (1969)); *United States v. Walker*, 335 F. Supp. 705 (N.D. Cal. 1971); *Cook v. Ciccone*, 312 F. Supp. 822 (W.D. Mo. 1970); *In re Harmon*, 425 F.2d 916 (1st Cir. 1970); *United States v. Klein*, 325 F.2d 283 (2d Cir. 1963); *Martin v. Settle*, 192 F. Supp. 156 (W.D. Mo. 1961); *Royal v. Settle*, 192 F. Supp. 176 (W.D. Mo. 1959)). As Justice Blackmun notes, the holdings in these federal cases create a “reasonableness” test, which establishes that unless there is a finding of dangerousness posed by the defendant to himself or others, a civilly committed person can only be held for a “reasonable period of time,” that period necessary to determine the likelihood of his regaining capacity to stand trial; if the likelihood is slim, then a civil commitment hearing must be held or the defendant released. *Id.*

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. The state of our knowledge of antipsychotic drugs and their side effects is evolving and may one day produce effective drugs that have only minimal side effects. Until that day comes, we can permit their use only when the State can show that involuntary treatment does not cause alterations raising the concerns enumerated in this separate opinion.<sup>215</sup>

Kennedy further warned that antipsychotic medication can prejudice the defendant during trial “in two principal ways: (1) by altering his demeanor in a manner that will prejudice his reactions and presentation in the courtroom, and (2) by rendering him unable or unwilling to assist counsel.”<sup>216</sup>

Because jurors, and even judges, watch the defendant closely during trial, a defendant’s demeanor, behavior, appearance, and more all combine to form an impression on the trier of fact that may greatly impact the outcome of the trial.<sup>217</sup> A state’s forced administration of antipsychotic drugs, with its potential to affect and prejudice the defendant during trial, implicates “serious due process concerns.”<sup>218</sup> For example, the drug administered to the defendant in *Riggins*, Mellaril, had a tranquilizer effect, and included side effects of “[d]rowsiness, constipation, perhaps lack of alertness, changes in blood pressure . . . [and] depression of the psychomotor functions.”<sup>219</sup>

However, the effects of antipsychotic drugs depend on which drug has been administered. Mellaril is among the least potent options for antipsychotic treatment, along with the drug Thorazine.<sup>220</sup> There are extremely potent antipsychotic medications, such as Prolixin and Haldol, which allow for smaller doses to get the same effects.<sup>221</sup>

Antipsychotic drugs will have different effects, depending on the specific drug administered and the defendant. However, such medications may create a “prejudicial negative demeanor in the defendant” by making him appear “nervous and restless” or by making him appear “so calm or sedated as to appear bored, cold, unfeeling, and unresponsive.”<sup>222</sup>

The potential for devastating side effects prejudices a criminal defendant by altering his outward appearance to the trier of fact, and also influencing or altering his ability to communicate,<sup>223</sup> which violates the constitutional due process right to prepare and present a complete defense.<sup>224</sup> A defendant must be able to communicate

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215. *Riggins*, 504 U.S. at 145 (Kennedy, F., concurring).

216. *Id.* at 142.

217. *Id.*

218. *Id.*

219. *Id.* at 143.

220. Ziegelmüller, *supra* note 207, at 838-39.

221. *Id.*

222. *Riggins*, 504 U.S. at 143 (Kennedy, F., concurring).

223. *Id.* at 144 (“[A] defendant’s right to the effective assistance of counsel is impaired when he cannot cooperate in an active manner with his lawyer.”) (citing *Massiah v. United States*, 377 U.S. 201 (1964)).

224. See generally *Chambers v. Mississippi*, 410 U.S. 284 (1973) (holding that rules of evidence, even if correctly applied, may violate due process if they deprive defendant of a fair trial and right to present a complete defense); *Holmes v. South Carolina*, 547 U.S. 319 (2006) (holding that a defendant has a right to present a complete defense, regardless of the sufficiency of the state’s evidence).

vital information to his lawyer about the case, to provide all the facts necessary to prepare a complete defense, and help develop theories of that defense. A defendant also has a fundamental right to communicate with the trier of fact, by testifying on the stand, if the defendant so chooses. The United States Supreme Court has also recognized a crucial right for a defendant to testify on his own behalf and to confront the witnesses against him.<sup>225</sup> By administering antipsychotic medication with the above potential side effects, the state interferes with these rights by affecting the way the defendant behaves in the courtroom and during pretrial proceedings.

*C. Existence of Less Intrusive Alternatives*

*“We can identify few legitimate medical procedures  
which are more intrusive  
than the forcible injection of antipsychotic medication.”*

—Judge Edward F. Hennessey<sup>226</sup>

Third, *Sell* requires that a court consider the existence of less intrusive alternatives to forcible medication before authorizing the treatment.<sup>227</sup> Courts must “exercise the least amount of judicial authority necessary to encourage defendants to accept prescribed medication without physically forcing them to ingest the medicine.”<sup>228</sup> The American Psychological Association, in an *amicus curiae* brief for *Sell*, discussed what may qualify as a “less intrusive alternative” to forced administration of antipsychotic medication.<sup>229</sup> First, a court must consider non-drug alternatives to treat the defendant, and must not resort to medication if non-drug alternatives would be effective.<sup>230</sup> Even though the brief acknowledged that there may be conditions that do not lend themselves to non-drug treatment, the brief argued that a court must not immediately order the forced medication.<sup>231</sup> It argued that the court still consider the probability of success of the proposed treatment in restoring competency, and determine whether the likelihood of success “substantially outweighs” the possibility of negative side effects.<sup>232</sup>

The state has the burden to demonstrate that there are no less intrusive alternatives to forced medication.<sup>233</sup> One alternative a court could utilize before forced medication is a court order to the defendant backed by the contempt power.<sup>234</sup> The United States District Court for the District of Maine explained in *United States v. Burhoe* that an order to take medication issued by a court backed by contempt power is a “less forceful exercise of judicial authority” than an order authorizing the

225. *Riggins*, 504 U.S. at 144-45 (Kennedy, J., concurring).

226. *In re Guardianship of Roe*, 421 N.E.2d 40, 52 (Mass. 1981).

227. *Sell v. United States*, 539 U.S. 166, 179 (2003).

228. *United States v. Burhoe*, 692 F.Supp.2d 137, 144 (D. Me. 2010).

229. See Mayelin Prieto-Gonzalez, *Supreme Court Limits Permissible Scope of Government's Ability to Force Medication of Mentally Ill Defendants*, 31 J.L. MED. & ETHICS 737, 738 (2003) (discussing *Sell v. United States*, including the American Psychological Association's *amicus curiae* brief).

230. *Id.*

231. *Id.*

232. *Id.*

233. Me. Dept. of Health and Human Services, *supra* note 130, at 2.

234. *Sell v. United States*, 539 U.S. 166, 181 (2003).

forcible medication of the defendant.<sup>235</sup> In the case of *Burhoe*, the defendant “indicated that he will abide by a court order” and would voluntarily take his medication.<sup>236</sup> This means that, should the defendant be responsive to a court order backed by contempt power, the result may be the defendant submitting to treatment by less invasive administration, such as swallowing pills. This is preferable over the defendant resisting treatment entirely, and forcibly medicating the defendant by injection.

Another possible alternative, before resorting to involuntary medication, is to mimic the process used by the military. The United States military has a different process for defendants deemed incompetent to stand trial, including a process for restoring competency that does not entirely consist of medication.<sup>237</sup> The restoration process of an incompetent service member begins with a four-month evaluation period, during which time the staff of the Federal Medical Center where the defendant is placed must determine whether there is “substantial probability” that the defendant will regain capacity to stand trial.<sup>238</sup> This process requires a thorough investigation to allow the staff to determine whether the defendant can be restored to capacity. The comprehensive assessment performed by the medical staff involves:

[A] physical examination and laboratory studies to rule out underlying medical illness; individual forensic interviews; review of documents describing the defendant's arrest; past criminal history; and review of any available past medical and mental health records. Psychological testing is offered, although sometimes defendants refuse to participate. Incompetent defendants are usually encouraged to attend the weekly one-hour competency restoration group, which provides basic education on competency issues in a small group setting.<sup>239</sup>

An accused may be required to stay for longer than four months, for a “reasonable” time period, if the court finds it likely that the defendant will regain capacity soon.<sup>240</sup> If, after the four-month evaluation period and possible additional evaluations, the defendant has still not been restored to capacity, then officials begin to consider psychotropic medication.<sup>241</sup> If the defendant does not accept the medication willingly, the accused typically receives a *Harper* hearing.<sup>242</sup>

A *Harper* hearing is based on the aforementioned *Washington v. Harper*, where the United States Supreme Court permitted forcible medication of an inmate who was determined to pose a dangerous threat to himself or others.<sup>243</sup> A *Harper* hearing begins by first requiring a twenty-four hour written notice of the hearing, along with an additional explanation of the rationale behind the proposed medical treatment.<sup>244</sup>

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235. *United States v. Burhoe*, 692 F. Supp. 2d 137, 144-45 (D. Me. 2010).

236. *Id.* at 145.

237. David M. O’Dea, *Navigating the Restoration of Capacity and Civil Commitment of a Mentally Incompetent Accused*, 2013 ARMY LAW. 3 (2013).

238. *Id.* at 4, 5.

239. *Id.* at 6 (quoting Bryon L. Hermel & Hans Stelmach, *Involuntary Medication Treatment for Competency Restoration of 22 Defendants With Delusional Disorder*, 35 J. AM. ACAD. PSYCHIATRY LAW 47, 50 (2007)).

240. *Id.* at 6.

241. *Id.* at 6, 7.

242. *Id.* at 7.

243. *Id.* at 7.

244. *Id.* at 7, 8.

The defendant has a right to be present at the hearing with a staff member from the medical center, to present evidence and request witnesses, and have the staff member question witnesses.<sup>245</sup> At the conclusion of the hearing, a psychiatrist who is impartial and not a part of the defendant's treatment at the facility will determine whether the defendant poses a danger to himself or others, and thus whether the defendant should be involuntarily medicated.<sup>246</sup>

*D. Important Government Trial-Related Interests*

*“In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires.”*

—Judge Fritz W. Alexander<sup>247</sup>

Lastly, before authorizing the forcible administration of drugs to treat the defendant, the court must consider whether there are important government trial-related interests at stake with the medication of the defendant.<sup>248</sup> It has been well established that conviction of an incompetent defendant is a violation of due process.<sup>249</sup> Justice Stevens, in his dissenting opinion in *Washington v. Harper*, argued that the decision of the majority did not protect, and indeed “undervalued,” the liberty interest of the defendant.<sup>250</sup> The liberty to be free from unwanted antipsychotic drugs is both “physical and intellectual,” and violation of bodily autonomy is an invasion of the dimensions of that liberty.<sup>251</sup> The most depraved invasion of that liberty is when the purpose of the involuntary medication is to alter the “will and the mind of the subject,” especially if the medication creates a substantial risk for irreparable injury or death.<sup>252</sup> Even after conviction of a crime, there are additional due process protections for a mentally ill defendant subjected to involuntary medication.<sup>253</sup> Substantive due process requires that involuntary medication of a prisoner with antipsychotic drugs may not be administered for any purposes, besides treatment of the prisoner within the prisoner's best medical interests.<sup>254</sup>

In the type of case at issue, where the State is attempting to force medication for the sole purpose of restoring competency of the defendant to stand trial, there can be no overriding important government interest. Safety of one's self and safety of others has been determined to be an important government interest, which justifies

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245. *Id.* at 8.

246. *Id.*

247. *Rivers v. Katz*, 495 N.E.2d 337, 341 (N.Y. 1986).

248. *Sell v. United States*, 539 U.S. 166, 179 (2003).

249. *Ziegelmüller*, *supra* note 207, at 845.

250. 494 U.S. 210, 237 (1990) (Stevens, J., dissenting) (“A competent individual's right to refuse psychotropic medication is a fundamental liberty interest requiring the highest order of protection under the Fourteenth Amendment.”).

251. *Id.*

252. *Id.* at 237-38.

253. *Id.* at 242.

254. *Id.*

involuntary medication in the State of Maine.<sup>255</sup> However, at issue is whether retribution—punishment of the defendant—is an important enough interest for the government to justify the displacement of a defendant’s fundamental right to privacy of one’s self and the right to refuse unwanted medical treatment.

In the case of Leroy Smith III, Smith is already incapacitated at the Riverview hospital, and is already located in a rehabilitative environment. Under current policies already in place without the involvement of the new Maine law, Smith has already been forcibly medicated when he has posed a threat to himself or others. Therefore, there are already medication procedures in place that conform to the important government interest of the safety of the patient and the safety of others. The State is seeking to create important trial-related interests, by forcing the necessary conditions to allow the trial to actually take place. However, this is only serving the desire to further punish the defendant, as the defendant is already being subjected to penological interests by remaining in the hospital.<sup>256</sup>

## VII. CONCLUSION

Unfortunately, the case of Leroy Smith III is no longer the only instance of forcible medication of a Maine pretrial defendant to restore competence to stand trial.<sup>257</sup> In March 2016, Kennebec County Superior Court again authorized forcible medication of a defendant who suffers from schizophrenia, antisocial personality disorder, and substance abuse issues.<sup>258</sup> While the case of Leroy Smith III was not appealed, the case of Ismail Awad was.<sup>259</sup> The Law Court heard oral arguments from the State and the ACLU of Maine, but has not yet rendered a decision regarding the forcible medication of Awad.<sup>260</sup> Of note, however, is the explicit indication of Chief Justice Saufley that she has “lingering concerns” over the forcible medication order.<sup>261</sup>

Even though *Sell* established the constitutionality of forcible medication of a pretrial defendant<sup>262</sup> as the *federal* standard, every conscientious Maine court should have lingering concerns. It is difficult to strike a careful *Sell* balance in federal court – but in Maine state court, not only is it difficult, it is also unwarranted. Maine’s

255. *State v. Patterson*, 582 A.2d 1204, 1206 (Me. 1990).

256. The Court alluded to this idea in *Sell*, by stating that “prolonged confinement due to a failure to take drugs, either before or after the competency hearing, ‘may lessen’ the significance of the government’s interest.” Christopher Slobogin, *The Supreme Court’s Recent Criminal Mental Health Cases: Rulings of Questionable Competence*, 22-FALL CRIM. JUST. 8, 9 (2007) (quoting *Sell v. United States*, 539 U.S. 166, 186 (2003)). The Court also indicated that, on remand, the lower court should consider the fact that the defendant had already been detained for a long time. *Id.* Because it remanded the case for further proceedings, the Supreme Court did not decide whether it thought the charges against *Sell* were “important” enough to justify involuntary medication in his case, but at least provided some guidance on the government interest prong. *Id.*

257. Edward Murphy, *State’s High Court Hears Arguments on Forcibly Medicating Crime Suspect*, PORTLAND PRESS HERALD (Oct. 26, 2016), <http://www.pressherald.com/2016/10/26/states-high-court-hears-arguments-on-forcibly-medicating-crime-suspect/>.

258. *Id.*

259. *Id.*

260. *Id.*

261. *Id.*

262. 539 U.S. 166, 186 (2003); see *supra* Part VI.

psychiatric centers and hospitals, such as the Riverview Psychiatric Center which houses defendant Smith, already had a unified treatment system in place before the Act.<sup>263</sup> The system already allowed for short-term, forcible treatment of patients who exhibit dangerous behaviors, so as to minimize and control present risk but in a manner limited by necessity.<sup>264</sup>

The application of the new Maine law was an attempt to fill a void that Maine does not have. As a result, forensic patients and pretrial defendants like Smith will face a long road of intrusive, damaging, forcible treatment of antipsychotic medications, for potentially indefinite periods of time. The government interest involved—retribution; punishment for crimes allegedly committed—is insufficient to excuse the trampling of personal liberties and due process rights of pretrial defendants, who remain innocent until proven guilty.

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263. *See supra* Part IV.

264. *Id.*