No. 02-5564

IN THE
Supreme Court of the United States

CHARLES T. SELL,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

MOTION OF THE DRUG POLICY ALLIANCE FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE* AND BRIEF OF *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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Interest of *Amicus Curiae*[*]

Established in 1994, the Drug Policy Alliance (formerly The Lindesmith Center) is dedicated to broadening the public debate over drug use and regulation and to advancing realistic policies, grounded in science, compassion, public health, and respect for human rights and individual autonomy. The Alliance is a non-profit, non-partisan organization with more than 20,000 members and active supporters nationwide. Through its Office of Legal Affairs, the Alliance has participated, as record counsel or *Amicus Curiae*, in litigation in this Court and various State and federal courts of appeals, concerning matters such as drug testing; access to substance abuse treatment and to treatment for patients suffering from severe and chronic pain; policies that disadvantage individuals with drug convictions or substance abuse problems and their families; and the use of medical marijuana and sacramental cannabis. At the core of these efforts is both concern that the fears, prejudices, and misconceptions that have, with regrettable frequency, infected this Nation's policies not be permitted to distort its constitutional law, and faith that courts will not permit government action, however well-intended, to trammel fundamental constitutional rights.

This case, which arises from government efforts to force hazardous, potent, mind-altering substances upon a non-dangerous individual against his will – solely that he might be made "competent" enough to stand trial for a non-violent offense – touches on matters of central concern to the Alliance.

Summary of Argument

By declining to apply the most demanding mode of judicial

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[*]This brief was not authored in any part by counsel for a party, and no one other than *Amicus* made a monetary contribution to its preparation or submission. Respondent, but not Petitioner, consented to its submission.

scrutiny, the Court of Appeals necessarily held that no liberty interest implicated here – including the freedom of a competent, non-dangerous individual to decide whether or not to ingest potent substances intended to alter his brain chemistry and thought processes (and known to threaten serious physical harm) – is "fundamental" under the Constitution.

Although no decision of the Court has specifically pronounced this freedom to be "fundamental," *see Riggins v. Nevada*, 504 U.S. 127, 136 (1992) (declining to prescribe level of scrutiny), both precedent and constitutional principle compel that conclusion.

The premise on which Petitioner's claim rests – that the individual is "sovereign over his own body and mind," J.S. MILL, ON LIBERTY 11 (Norton ed. 1975) – is one that is implicit in the concept of ordered liberty and that has found consistent expression in the common law; in this Court's First, Fourth, and Fifth Amendment jurisprudence; and in its decisions describing the "realms" where, as a matter of Due Process, "the state cannot enter."

Forcible administration of medication is itself a substantial infringement on dignity and bodily security, and as this Court's recent decisions describe, the specific drugs here at issue are potent and invasive in their intended operation. Their unintended effects can be disturbing, debilitating, even lethal.

To be sure, the benefits of these drugs are such that many individuals risk their dangers and endure their adverse effects, but those harms surely highlight the seriousness of divesting Petitioner of power to make the decision for himself. The common law and Due Process precedents underlying Petitioner's claim do not rest on the assumption that the individual is better situated than a government doctor to determine what is "medically appropriate," but rather that, in

making important decisions concerning his body and mind, the individual must be free to reject medical expertise or evaluate in light of personal experiences and broader conceptions of what is right, important and meaningful in life.

That this case involves a government effort to alter Petitioner's brain, with the avowed intent of changing his thought process, provides further, urgent reason for stringent scrutiny. There is no need to impute to doctors and officials in this case any sinister "mind control" agenda to recognize that government action that seeks to change a person's thinking, against his will, is deeply at odds with longstanding conceptions of constitutional "liberty." The Constitution protects private thoughts, ideas, and feelings – including those (such as Petitioner's, perhaps) unlikely to spark the discovery of broader political and philosophical truths – and its various express guarantees presuppose that an individual controls his own thinking process.

These concerns cannot be defined away by describing the action as "restoring" the individual to his "true self" – or as enhancing the quality or coherence of his thinking. Not only do such metaphors entail important oversimplification, and it but they run aground on a more basic objection: that the power to define oneself (or to choose among "better" or worse versions) is precisely what the Due Process Clause denies the government. If decisions concerning family, procreation, and child-rearing are "fundamental" based on their nexus to "personhood," then similar protection for the individual's mental life – his personality – must follow *a fortiori*.

Nor does acknowledgment that certain individuals lack capacity to make treatment decisions for themselves make these liberties less fundamental, either for those persons or others who, though mentally ill, retain that capacity. The assumption

that individuals suffering from mental illness are incapable of giving (and withholding) informed consent, though long clung to, has been disproved as a matter of fact and has been repudiated, almost universally, as a matter of law. And it has been a central teaching of this Court's liberty jurisprudence that such discredited preconceptions may not be allowed to deprive individuals of fundamental interests.

Although *Amicus* would submit that the constitutional stature of the liberty interest asserted does not depend on the context in which this case arises, the criminal trial setting surely strengthens Petitioner's claim to have his decision respected. The government intervention here is not even ostensibly therapeutic – the United States sought the order not as *parens patriae*, but as Petitioner's adversary in a criminal proceeding – and the interests Petitioner asserts, to be free from substances that will alter his cognition, appearance, sense of well-being, and affect, are bound inextricably with core rights guaranteed the accused under the Fifth and Sixth Amendments.

Finally, although this case does not call for a categorical pronouncement, we submit that – unlike the government's interests in preventing harm to others and in providing for the well-being of those without capacity to do so – the interest advanced here, described as that of "obtaining an adjudication of guilt or innocence," is not sufficiently "compelling" to support the infringement of liberty. The government's only legitimate interest is in obtaining a fair and accurate adjudication, a result that involuntary medication by no means necessarily advances, *see Riggins* (Kennedy, J., concurring in judgment). And unlike the other, long-recognized rationales for involuntary medical treatment, this awkwardly described interest rests on a jarring assumption: that the government's interest in obtaining a not guilty verdict should override the wrongly accused individual's interest in remaining free of

potent, potentially lethal substances. Finally, unlike other interests that are truly compelling, the interest in a prompt, dispositive adjudication is one the government itself regularly subordinates, in the pursuit of other interests, both important and constitutionally mundane.

I. Forcible Administration Of Potent, Mind-Altering Substances Requires Strict Scrutiny

In *Washington v. Glucksberg*, the Court reaffirmed that certain liberty interests are so firmly rooted in the "Nation's history and constitutional traditions" that Due Process allows their infringement only by government action narrowly tailored to achievement of a compelling interest. 521 U.S. 702, 721 (1997).[1] Although the decision below acknowledged that the Government's effort to administer antipschytoic drugs, over Petitioner's objection, implicated a "liberty" interest under the Constitution, *see* 282 F.3d at 565-66 (citing *Riggins* and *Washington v. Harper,* 494 U.S. 210 (1990)), it expressly refused to undertake the searching scrutiny indicated when "fundamental" freedoms are threatened, *id.* at 567 n.7.

Neither the Eighth Circuit's stated reasons nor this Court's precedents support that decision. First, *Riggins* did not, as the Court of Appeals indicated, "decline" to apply strict scrutiny, *id.* at 567 – it declined to decide the level-of-scrutiny question, *see* 504 U.S. at 136 – and *Harper* relied on precisely the mode of analysis that applies whenever "fundamental" rights are asserted against prison officials. *Turner v. Safley*, 482 U.S. 78, 89 (1987) (deciding "reasonableness" of restriction on right to

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[1] Although this case involves the Due Process Clause of the Fifth Amendment and not (as do many of the cited precedents) the identically-worded Fourteenth Amendment clause, the substantive liberties the two provisions protect are coextensive. *See Ingraham v. Wright*, 430 U.S. 651, 672 (1977); *see also Bolling v. Sharpe*, 347 U.S. 497, 500 (1954).

marry); *O'Lone v. Estate of Shabazz*, 482 U.S. 342 (1987).

In fact, principled application of this Court's precedents compels the conclusion that the freedom at stake here – that of a non-dangerous individual (convicted of no crime) to decide against administration of powerful, mind-altering substances – is "fundamental."

A. Under This Court's Precedents. Petitioner's Bodily Integrity And Autonomy Interests Are Fundamental

The measures the Government seeks to take – intramuscular injection of powerful chemical agents intended to alter Petitioner's thinking process – are an undeniable imposition on his bodily integrity and "physical security"– interests long recognized as "implicit in the concept of ordered liberty," *Palko v. Connecticut*, 302 U.S. 319, 326 (1937), and thus, fundamental. *See Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 287 (1990) (O'Connor, J., concurring) (the "Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause"); *Rochin v. California*, 342 U.S. 165 (1952); *Ingraham*, 430 U.S. at 673; *United States v. Stanley*, 483 U.S. 669, 685 (1986) (O'Connor, J., concurring) (quoting Nuremberg Tribunal's conclusion that "voluntary consent of the human subject [to medical experiment] is absolutely essential * * * to satisfy moral, ethical and legal concepts"); *see also Pratt v. Davis*, 118 Ill. App. 161, 166 (1905) ("under a free government at least, the free citizen's first and greatest right, which underlies all others [is] the right to the inviolability of his person").

Although antipsychotic drugs are not the most invasive intervention conceivable, *see, e.g.*, B. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT (1997) 103-115 (discussing psychosurgery), the methods by which they are administered to unwilling individuals go far beyond what is

"routine in our everyday life," *Breithaupt v. Abram*, 352 U.S. 432, 436 (1956). *See Harper*, 494 U.S. at 229 ("[t]he forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty"). *Compare Breithaupt*, 432 U.S. at 436 (describing taking of blood, which "literally millions of us" have experienced) *and Jacobson v. Massachusetts,* 197 U.S. 11, 32 (1905) (noting pervasive vaccination of schoolchildren) *with* Joint App. *Mills v. Rogers*, No. 80-1417 at 170-71 (patients were "physically restrained, pants removed, injected with antipsychotic drugs through a hypodermic needle in the buttocks, at times in full view of other patients or staff"). Injection is not a one-time occurrence, *compare Rochin* (stomach pumping); *Winston v. Lee*, 470 U.S. 753 (1985) (surgical procedure), and because "there is no accurate method of determining how a patient will respond to a particular drug," selection of medication and dosage levels are arrived at on a "trial and error" basis. W. Brooks, *Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs*, 31 IND. L. REV. 937, 946 (1998).

Once injected, the drugs operate directly on the brain's chemistry, in ways that are not fully understood, and that have been found to have lasting effect on brain structure. *See* P. Harrison, *Review: The Neuropathological Effects of Antipsychotic Drugs*, 40 SCHIZOPHRENIA RES. 87-99 (1999). Moreover – without stinting the efficacy of these medications or the genuine relief that they have brought to many suffering from mental illness (and without suggesting that Petitioner's decision is in any objective sense "correct", *see infra*) – judicial notice has been taken of the "serious, even fatal, [physiological] side effects" these drugs cause. *Riggins*, 504 U.S. at134; *see* B. Winick, *The Right to Refuse Mental Health Treatment: A First Amendment Perspective*, 44 U. MIAMI L. REV. 1, 70

(1989) (underscoring that, although adverse effects are "unintended, they are intrinsic to the drugs' benevolent properties and should not be trivialized, particularly since patients frequently experience them to be distressing enough to outweigh the drugs' positive clinical effects"); *cf. Stone v. Smith, Kline & French Labs.*, 731 F.2d 1575 (11th Cir. 1984) (sustaining conclusion that that Thorazine is "unavoidably unsafe" under RESTATEMENT (SECOND) OF TORTS § 402A); *Winston*, 470 U.S. at 761 (citing cases disallowing surgical procedures that, while likely to uncover evidence, would "endanger[] the life or health of [a] suspect").[2]

Among the documented effects of standard antipsychotic drugs are sedation, blurred vision, serious blood disorders, and an array of neuromuscular effects, including Akathesia – "uncontrollable physical restlessness, agitation, pacing, anxiety

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[2]We note that newer, "atypical" antipsychotic drugs have been found to present side effect profiles that are different from and, in some respects less serious than those canvassed in *Riggins*. *See, e.g.*, D. Siegel, et al., *Old Law Meets New Medicine: Revisiting Involuntary Psychotropic Medication of the Criminal Defendant*, 2001 WIS. L. REV. 301, 349.

Although all should hope that these recently introduced agents fulfil their promise of delivering greater relief, with less onerous adverse effects, it bears emphasis that the long-term effects of these drugs remain largely unknown and that, like the far more prevalent, "typical" medications, they are indisputably potent, mind-altering substances, which can cause serious adverse health effects. *See infra.* Their relevance to Petitioner's case is further limited because (a) few of these drugs are currently available in a form (*i.e.*, injectable) that can be administered involuntarily, and (b) Petitioner suffers from delusional disorder, rather than schizophrenia, *see* DSM-IV-TR at 324, the disorder for which their therapeutic efficacy principally has been claimed.

But in any event, the Constitution's protection for self-determination in these matters is not dependent on any particular balance of harms and benefits.

and panic"; Akinesia – a "state characterized by unspontaneous speech, apathy and a difficulty in initiating activities"; dystonia – which is "characterized by muscle spasms, particularly in the eyes, neck, face and arms"; and tardive dyskinesia – a late-developing, often irreversible and untreatable condition characterized by involuntary movements of facial, arm, leg, or truncal musculature and, in more serious cases, by "difficulty [in] swallowing, talking and breathing ." Brooks, 31 IND. L. REV. at 947-49. Although newer antipsychotics have not been associated with tardive dyskinesia, they by are no means free of neuromuscular or other, even more serious, adverse effects.[3]

Significantly, some of these effects are themselves misunderstood and poorly diagnosed. For example, "[b]ecause

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[3]For example, 13% of those taking ziprasidone experience akathsia and 7% experience dystonia, rates that are substantially lower than those for Haloperidol (17% and 20%, respectively), but remain significant. *See* http://cebmh.warne.ox.ac.uk/cebmh/elmh/schizophrenia/tx/antipsychotics; *See* also B. WINICK, *supra* at 77 n. 80 (noting connection between clozapine and agranulocytosis, a serious hemological disorder).

Moreover, neuroleptic malignant syndrome (NMS) – which causes fever, skeletal rigidity, elevated blood pressure, delirium, mutism, stupor and coma and, in an estimated 20% to 30% of cases, death – has been associated with atypical, as well as typical drugs. J. Karagianis, et al. *Clozapine-Associated Neuroleptic Malignant Syndrome*: 33 ANN. PHARMACOTHERAPY 623-30 (1999). Although "relatively rare," *Riggins*, 504 U.S. at 134, "a conservative estimate would place the annual prevalence of neuroleptic malignant syndrome in the United States in the thousands of cases." H. Pope, et al., *Frequency and Presentation of Neuroleptic Malignant Syndrome in A Large Psychiatric Hospital*, 143 AM. J. PSYCH. 1227, 1231 (1986). *See also* D. Pinals & P. Buckley, *Novel Antipsychotic Agents and Their Implications for Forensic Psychiatry*, 27 J. AM. ACAD. PSYCH. & L. 7 (1999) (other effects of atypical drugs "include orthostatic hypotension, tachycardia (an abnormally fast heartbeat), excessive salivary flow, sedation, elevated temperature, weight gain, agitation, insomnia, headaches, nausea, sedation, constipation, dyspepsia, and somnolence").

psychiatrists often misinterpret symptoms of akathesia as a worsening of a patient's psychiatric condition, physicians will react by increasing the dosage level of medication." Brooks, 31 IND. L. REV. at 948 (citing P. Weiden, et al., *Clinical Nonrecognition of Neuroleptic-Induced Movement Disorders: A Cautionary Study*, 144 AM. J. PSYCH. 1148, 1151 (1987)), and medications used to manage neuromuscular effects cause their own adverse effects. *See* S. Marder, *Schizophrenia: Somatic Treatment*, in KAPLAN & SADOCK'S COMPREHENSIVE TEXTBOOK OF PSYCH. 1199, 1205 (B. Sadock & V. Sadock eds., 7th ed. 2000).

Even then, the drugs are not a "cure." A significant minority of patients do not respond to them at all, *see* B. WINICK, *supra*, and, for those who respond positively, the beneficial effects require continuous medication. *See Riese v. St. Mary's Hosp. & Med. Ctr.*, 271 Cal. Rptr. 199 (Cal. App. 1987) ("The drugs are palliative rather than curative"). They have relatively little effect on "negative" symptoms of pscychosis, *i.e.* "social isolation, apathy, and decreased communicativeness" – which are both "debilitating" and"more significant for prognosis and over-all outcome [than] the symptoms * * * amendable to a pharmacological approach." S. Keith, *Drugs: Not the Only Treatment*, 33 HOSP. & COMMUNITY PSYCH. 793 (1982).

While the variety and intensity of these physical effects (along with effects on mentation, *infra*, individuals' subjective experience of their unmedicated state, their prior responses to medication, and their concepts of health and autonomy) help to make refusal decisions comprehensible, *see Harper*, 494 U.S. at 239 (Stevens, J, concurring in part, dissenting in part) (noting prison records indicating that respondent had "stated he would rather die th[a]n take medication"), they do not establish that that they are "medically inappropriate" or that, in any

objective sense, their burdens outweigh their benefits.[4]

On the contrary, it is a measure of their therapeutic benefit that many more individuals continue to consent to, rather than refuse, their administration, and those who do often report dramatically positive results. *Cf. Rogers v. Okin,* 478 F. Supp. 1342, 1369 (D. Mass.1979) (noting that only 12 of 1,000 institutionalized patients refused psychotropic drugs for prolonged periods during pendency of judicial supervision), *modified,* 634 F.2d 650 (1st Cir.1980), *vacated and remanded sub nom. Mills v. Rogers,* 457 U.S. 291 (1982). And while the evidence of appropriateness in this case is disturbingly thin,[5] the

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[4]Notably, studies confirm that objectively verifiable adverse effects are a prominent reason for drug refusal. T. Van Putten, et al., *Subjective Response to Antipsychotic Drugs*, 38 ARCHIVES GEN. PSYCH. 187, 189-90 (1981); *see also* S. Hoge, et al., *A Prospective Multicenter Study of Patients' Refusal of Antipsychotic Medication*, 47 ARCHIVES GEN. PSYCH. 949, 954 (1990) (35% of patients cited side effects as reason for refusal, but treating physicians identified patient concern about side effects in only 7% of cases).

[5]The Court of Appeals pronounced that the district court had not committed "clear error" in concluding that "clear and convincing" evidence that antipsychotic medication was "medically appropriate" in Petitioner's case. *See* 282 F.3d at 570. At the outset, the appellate court opinion betrays a more causal approach to the record evidence than that standard contemplates – *e.g.*, characterizing a doctor as having a "50% success rate," *id.*, when he had testified that he had only encountered two such cases.

Even more significant, Petitioner presented psychiatric testimony that antipsychotic drugs were far less effective in treating his condition, delusional disorder, than schizophrenia, supported by a medical text confirming that assertion and a report from the forensic psychologist at Petitioner's detention facility stating that "delusional disorders do not typically respond to medication," *id.* Although the court described the treatise as noting "disagreement between experts" on the point, and quoted the testimony of the government's witness to the effect that – based on seven patients he had treated – "he doubted the accuracy," *id.* at 569, of the the medical literature concerning delusional disorder, it almost surely was

medical literature consistently reports benefits for large percentages of people who take them, *see Harper*, 494 U.S. at 226 n.9, and, for many individuals, no comparably effective alternative treatment is known. *See Riese*, 271 Cal. Rptr. at 203 (describing antipsychotic medication as "principal and single most effective treatment" for acute psychoses). It is unsurprising that individuals who have first-hand experience with these benefits would be puzzled or disturbed by judicial respect for an individual's decision not to take them. *Cf. Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 852 (1993) (protecting woman's freedom to make abortion decision, though noting that it is viewed by "some [as] nothing short of an act of violence against innocent human life").

But to state these real benefits and (no less real) risks is to underscore another fundamental aspect of liberty implicated here: the individual's freedom to decide whether or not to accept medical treatment, however appropriate. That freedom was implicitly recognized in *Riggins* – which established that "medical[] appropriate[ness]" is a necessary, but not sufficient precondition for involuntarily administering antipsychotic drugs, *see* 504 U.S. at 135 – and like the closely related interest in bodily security, it is rooted in basic concepts of self-ownership.

As *Cruzan* and *Glucksberg* document, the right to decide whether to accept medical treatment is "firmly entrenched in American tort law," 497 U.S. at 267, and protected by the Due Process Clause. *See Meyer v. Nebraska*, 262 U.S. 390, 399

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clear error for a court to have determined that the evidence on this point was "clear and convincing." *See United States v. Montague*, 40 F.3d 1251, 1255 (D.C. Cir. 1994) (describing that evidentiary standard as "most akin to the process of evaluating testimony 'in a light most favorable to the defendant'").

(1923) (defining as fundamental, "those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men"); *cf. Rogers,* 634 F.2d at 653 (calling it "intuitively obvious" that "a person has a constitutionally protected interest in being left free by the state to decide for himself whether to submit to the serious and potentially harmful medical treatment that is represented by the administration of antipsychotic drugs").

This right has been held effective against interventions that are less physically disruptive than those at issue here, *Cruzan* (assuming constitutional "right to refuse lifesaving hydration and nutrition"); *In re Osborne*, 294 A.2d 372 (D.C. 1972) (refusing to order blood transfusion), where the therapeutic benefit is both more clear and more enduring, *id.* (noting that transfusion would quickly restore health), where the alternative is more stark, *In re Quackenbush*, 383 A.2d 785 (N.J. Super. 1978) (death within three weeks, in the absence of amputation); *Lane v. Candura*, 376 N.E.2d 1232 (Mass. 1978); and where the reasons for refusal are inscrutable or eccentric, *see id. See also Application of President & Directors of Georgetown College, Inc.*, 331 F.2d 1010, 1016-17 (D.C. Cir. 1964) (Burger, J., dissenting) (right of privacy includes "great many foolish, unreasonable and even absurd ideas * * * such as refusing medical treatment even at great risk").

The reasons why law nonetheless treats the individual's decision as inviolable are rooted in respect for autonomy. In most cases, as here, the competing benefits and burdens are experienced overwhelmingly, usually exclusively, by the patient. *See* 282 F.3d at 565 (sustaining district court finding that Petitioner is not dangerous to others); *Casey*, 505 U.S. at 852 (noting that the "mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear" and concluding that State's interest in compliance

with its "vision of the woman's role" did not allow it to "insist * * * she make the sacrifice"); *Pratt*, 118 Ill. App. at 166 (patient's "right to himself * * * necessarily forbids a physician or surgeon, however skillful * * * to violate without permission [his] bodily integrity").[6]

Further, even where the competing benefits and risks can be roughly quantified – a 50% chance that a condition will improve as a result of invasive therapy, but a 10% chance that medication will produce a different, undesirable effect – there is often no obvious, objective basis for identifying the "correct" choice. *Cf. Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972) ("The weighing of these risks against the individual subjective fears and hopes of the patient * * * is a nonmedical judgment reserved to the patient alone").

The law recognizes that how individuals reach decisions under these circumstances is inescapably personal, summoning their values, ethical and religious principles, and conceptions of what makes their own lives worthwhile and meaningful - realms where government (and medical science), to the limited extent they are competent to speak, may not exercise a veto. *West Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1944); *Casey*, 505 U.S. at 851 ("At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."); *In re*

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[6]In contrast, autonomy rights sometimes yield where other individuals are directly threatened. *See Riggins*, 504 U.S. at 135 (antipsychotic medication permissible if "medically appropriate and, considering less intrusive alternatives, essential for the sake of * * * the safety of others"); *Jacobson*, 197 U.S. at 26 (danger of smallpox outbreak); *see also Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson*, 201 A.2d 537 (N.J. 1964) (requiring blood transfusion in case of woman carrying 34-week-old fetus). Notably, the inmate plaintiff in *Harper* was found to have been dangerous without medication. *See* 494 U.S. at 217.

Osborne, 294 A.2d at 374 (declining to order blood transfusion for patient who believed that it would deprive him entry to "new world where life will never end"). *See generally Belchertown State School v. Saikewicz*, 370 N.E. 2d 417 (Mass. 1977) (the "right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice"); *Rivers v. Katz*, 495 N.E. 2d 337, 343 (N.Y. 1986).

B. Actions Impinging On Mental Autonomy Warrant Special Constitutional Concern

That this case entails an unwanted intrusion directed at the individual's brain, with the avowed purpose of altering his thought process, *see Harper*, implicates special constitutional concern – and can not possibly supply a rationale for less vigilant constitutional scrutiny. *See* L. TRIBE, AMERICAN CONSTITUTIONAL LAW 1312 (2d ed. 1988) (describing "attempt to determine the contents and processes of mind" as the "starkest form of government invasion of personality"); *cf. Rochin*, 342 U.S. at 173 ("It would be a stultification of [judicial] responsibility * * * to hold that in order to convict a man the police cannot extract by force what is in his mind but can extract what is in his stomach").

In arguing that the exercise of sovereignty over the mind is entitled to special protection, we do not rely on (and would explicitly disavow) any suggestion that administration of antipsychotic drugs under these circumstances constitutes "mind control" – with its sinister connotations of suppressing government-disapproved ideas and replacing them with thoughts more acceptable to those in power, *see Barnette*, 319 U.S. at 643. Nor do we suggest that government need be strictly neutral between ordered and disordered thinking or that

delusions (such as Petitioner's) carry any significant potential to promote "the discovery * * * of political truth." *See Whitney v. California*, 274 U.S. 357, 375 (1927) (Brandeis, J., concurring); *but cf.* R. LAING, THE POLITICS OF EXPERIENCE 129 (1967) (predicting that society would eventually come to see "that what we call 'schizophrenia' []as one of the forms in which, often through quite ordinary people, the light began to break through the cracks in the all-too-closed minds").

But even with these provisos in place, the power to "alter the chemical balance in a patient's brain, leading to changes, * * * in his or her cognitive processes," *Harper*, 494 U.S. at 214 – even if undertaken with the aim of "enabling" thought processes – is one in grave tension with basic understanding of constitutional "liberty." This Court's cases have repeatedly recognized that the realm of thought is one more completely privileged against government intrusion than conduct, or even expression. *Stanley v. Georgia,* 394 U.S. 557, 565-56 (1969); *Jacobson v. United States*, 503 U.S. 540, 551-52 (1992) ("a person's inclinations and 'fantasies * * * are his own and beyond the reach of government'") (quoting *Paris Adult Theatre I v. Slaton,* 413 U.S. 49, 67 (1973)); *Jones v. Opelika*, 316 U.S. 584, 618 (1942) (Murphy, J., dissenting) ("[f]reedom to think is absolute of its own nature; the most tyrannical government is powerless to control the inward workings of the mind."), *rev'd*, 319 U.S. 103 (1943)); *see also Wooley v. Maynard*, 430 U.S. 705, 714 (1977) (describing free speech as a "component[] of the broader concept of individual freedom of mind").[7]

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[7]Although we describe this liberty in Fifth, rather than First Amendment terms – in view of the inseparability of Petitioner's bodily and mental integrity claims – the Court's First Amendment doctrine would surely indicate a similar result. Notably, though the precedents cited above are often referred to as "First Amendment" decisions, they are more

The rationale for treating thought processes as largely "beyond the reach of government" rests not on the notion that they are "harmless," but rather on the understanding that they are important, because other freedoms the Constitution guarantees presuppose autonomous thought. Thus, "[f]reedom of expression would be illusory if government could intrude directly into mental processes to alter the very thoughts, beliefs, or attitudes that would be expressed," Winick, 44 U. MIAMI. L. REV. at 31, and as Justice Cardozo famously asserted, "freedom of thought" is "the matrix, the indispensable condition, of nearly every other form of freedom." *Palko*, 302 U.S. at 327; *see also Riggins*, 504 U.S. at 139 (Kennedy, J., concurring in judgment) (defendant's competence "is rudimentary, for upon it depends the main part of those rights deemed essential to a fair trial").

Indeed, where previous precedents, recognizing as fundamental an individual's interest in deciding whether to bear or beget a child, to use contraceptives, or to send a child to private school, have stressed how closely those decisions relate to "personhood," the correspondence between an individual's ideas and mental life and his "identity" and "personality" is understood, in our culture, to be much more direct. To protect the former, but not the latter, would be inconsistent with a commitment to principled exposition of constitutional rights. *See Rochin*, 342 U.S. at 173; *Moore v. East Cleveland*, 431 U.S. 494, 501 (1977) ("Unless we close our eyes to the basic reasons why certain rights * * * have been accorded shelter under the * * * Due Process Clause, we cannot avoid applying the force and rationale of these precedents to the * * * choice involved in this case"); *Poe v. Ullman*, 367 U.S. 497, 543

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precisely described as giving effect to "substantive liberties protected by * * * Fourteenth Amendment" Due Process. *Casey*, 505 U.S. at 847.

(1961) (Harlan, J., dissenting).

These concerns cannot be answered by describing medication as simply "restoring" the individual to his "true self" or by stressing that antipsychotic drugs are intended to (and surely often do) enhance the quantity and coherence of thinking – or suggesting that they operate, with scalpel-like precision, to "clear" only the "sick" thoughts and correct those thinking processes are pathological. But such reassuring metaphors are neither descriptively accurate nor constitutionally satisfactory.[8] *Compare e.g.*, Siegel, et al., 2001 WIS. L. REV. at 349 ("[t]he mechanism of action for [atypical] medications is still not fully known"). Even while suffering mental illness, individuals are capable of expressing important insight, *see, e.g.*, R. PORTER, A SOCIAL HISTORY OF MADNESS: THE WORLD THROUGH THE EYES OF THE INSANE (1987), and even were it possible to untangle thoughts that were "tainted" by illness from those which were not – *see United States v. Brawner*, 471 F.2d 969, 981-83 (D.C. Cir. 1972) (*en banc*) (overruling decision

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[8]It has been claimed that the "'[t]he mental health produced by antipsychotic medication is no different from no more inauthentic or alien to the patient than, the physical health produced by other medications, such as penicillin for pneumonia.'" Br. *Amicus Curiae* of Amer. Psychiatric Ass'n, *Riggins v. Nevada*, at 9 (quoted in *id.* at 141 (Kennedy, J., concurring in judgment)). But unlike pneumonia, which is often caused by a known agent (*streptococcus pneumoniae*) and definitively diagnosed through laboratory tests, diagnosis for mental illness is far less exact, and the understanding of etiology is far more speculative. *See* Winick 44 U. MIAMI L. REV. at 49 ("Diagnostic reliability – the probability that two clinicians will agree with each other's diagnosis – is only fifty to sixty percent for schizophrenia"); *see Ake v. Oklahoma*, 470 U.S. 68, 81 (1985) (noting that "psychiatrists disagree widely and frequently on what constitutes mental illness"). As noted above, moreover, antipsychotic drugs do not "cure" the patient, in that their beneficial effects often do not persist beyond their administration and they are generally ineffective against important, "negative" dimensions of the illnesses they are meant to treat.

linking insanity defense to proof that crime was "product" of mental illness) – this Court's cases indicate that even the former would be entitled to solicitude. *Slaton,* 413 U.S. at 67, (the "fantasies of a drug addict are his own and beyond the reach of government'"); *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (First Amendment protects "emotions and * * * sensations," no less than ideas); *cf. Cohen v. California*, 415 U.S. 25, 26 (1971) (abandoning effort to distinguish between "ideational and emotional" speech). Indeed, evidence increasingly supports a more integral relationship between certain highly valued forms of expression and thought processes generally understood to require treatment. *See* K. JAMISON, TOUCHED WITH FIRE: MANIC DEPRESSIVE ILLNESS & THE ARTISTIC TEMPERAMENT (1996) (collecting evidence of association between bipolar disorder and creativity); Winick, 44 U. MIAMI L. REV. at 78 & n. 472 (citing studies finding that some artists refuse medication prescribed for bipolar disorder).

Indeed, the assertion that alteration of the brain is unproblematic because thoughts are shifted in the direction of "normalcy" obscures basic constitutional considerations. The freedom to choose among "better," worse, or more normal versions of oneself is precisely what the Constitution vests in the individual. Thus– without denying the reality of mental illness or the minimizing the pain it causes – there are surely individuals for whom the experiences and thought process of an unmedicated state are, for some reasons, preferable to those experienced after medication. For some individuals, the "sanity" that medication delivers, even if "authentic," *see* n. 9, *supra*, is illegitimate, as a matter of religious scruple, *see Winters v. Miller*, 446 F.2d 65 (2nd Cir. 1971). For others, the effects of the medication – both those which are strictly "cognitive" and those neurological effects that impinge on their efficacy and self-concept do make the medicated state seem "alien" and undesirable.

Finally (and likely least comprehensible) are individuals who affirmatively embrace a condition the world regards as painful and disabling. Although it is tempting to discount any such preference as a manifestation of illness, even within the psychiatric profession, there remains a "distinct minority" who have contended that aspects of schizophrenic thinking are a "'growth experience,'" which can "'open[] new paths of feeling and understanding.'" *See* Winick, U. MIAMI L. REV. at 54 (quoting S. ARIETI, INTERPRETATION OF SCHIZOPHRENIA 121, 378-79 (2d ed.1974)). Although a court required to weigh the available evidence might well decide in favor the majority of the profession, it surely should hesitate before pronouncing impermissible the medication decision of an individual, who poses no danger to others and subscribes, sincerely, to this dissenting "concept of existence [and] meaning." *Casey*, 505 U.S. at 851.

C. That Some Individuals Suffering From Mental Disorders Lack Competency To Make Treatment Decisions Is No Basis For Finding The Autonomy And Integrity Interests Less "Fundamental"

In refusing to apply strict scrutiny, the decision below did not grapple with the distinct constitutional concerns implicated by chemical "mind alteration," or even offer any basis for distinguishing between the autonomy and integrity interests implicated by involuntary injection of antipsychotic drugs and those at stake in other medical treatment situations where liberty interests are undeniably fundamental. *See Rivers*, 495 N.E. 2d at 343 ("if we were dealing here with an ordinary patient suffering from a physical ailment, the hospital authorities would have no right to impose compulsory medical treatment against the patient's will and indeed, that to do so would constitute a common law assault and battery").

Although two conceivably distinguishing features

suggest themselves – that not all persons suffering from mental illness have the capacity to make treatment decisions for themselves and that, historically, courts treated all mentally ill persons as lacking capacity to give (or withhold) consent, *see, e.g.*, *Denny v. Tyler*, 85 Mass. 225, 229 (1861) – neither one supports the Eighth Circuit's choice of less-than-strict scrutiny.

First, as *Cruzan* illustrates, whether a liberty interest is "fundamental" does not depend on whether the individual is personally competent to assert it. Even for individuals whose mental illness does prevent them from making treatment decisions, lack of capacity does not make less real the violation of bodily integrity that forcible medication entails – nor do individuals, by lapsing into incapacity, forfeit their interest in having their religious tenets and personal values respected. *See In re Guardianship of Roe*, 421 N.E.2d 40, 52 (Mass. 1981).

But equally important, the assumption that all individuals suffering from mental illness – or most (or even those ruled incompetent to stand trial) – are incapable of making an informed treatment decision has, as an empirical matter, been discredited:

> Although mental illness sometimes impairs competency to process information and make rational choices, it often does not * * * * Mentally ill people have a significant capacity for normal and rational thought and behavior * * * * Even in the midst of a psychotic episode, mentally ill people function normally some of the time. Moreover, such episodes are intermittent, and between episodes clinicians find it difficult to distinguish with a high degree of certainty "crazy" people from "normal" people.

Winick, *Competency to Consent to Treatment*, 28 HOUS. L. REV. 15, 38-39 (1991); *see* T. Grisso & P. Appelbaum, *The Macarthur Treatment Competence Study, III: Abilities to*

Consent to Psychiatric and Medical Treatment, 19 LAW & HUM. BEHAV. 149, 169-71 (1995) (finding that "on any given measure of decisional abilities, the majority of patients with schizophrenia did not perform more poorly than other patients or nonpatients" and concluding that denial of decisional right "can not be based on the assumption that [such individuals] lack decisional capacity"); Siegel, 2001 WIS. L. REV. at 365 ("Competence to consent to treatment is a functional ability distinct from competence to stand trial, that must be examined separately before involuntary medication to establish competence to stand trial is considered").[9]

These empirical realities have had a powerful effect on the law. It is now standard that individuals are presumed competent, until adjudicated otherwise, and where, traditionally, "an adjudication of incompetency * * * placed [an individual] under total legal disability, * * * [t]he law has moved strongly away from this notion." Winick, 28 HOUS. L. REV. at 23. "Even those who have been involuntarily committed to mental hospitals because they are incompetent to decide about hospitalization are presumed competent to make other decisions," *id.* at 39, and almost every State provides that individuals who are involuntarily committed retain common law and civil rights.[10] *See, e.g., Goedecke v. State Dep't of*

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[9]Unlike other disorders, the pathology of delusional disorder often manifests itself in limited realms, *i.e.*, those aspects of the individual's existence that give rise to the delusional material.

[10]*See* Ark. Code Ann. § 20-47-223; Cal. Welf. & Inst. Code § 5331; Colo. Rev. Stat. § 27-10-104; Conn. Gen. Stat. Ann. § 17a-541; D.C. Code Ann. § 21- 564; Fla. Stat. Ann. § 394.459(1); 405 Ill. Comp. Stat. Ann. 5/2-101; Ind. Code Ann. § 12-27-2-3; Iowa Code Ann. § 229.27; Kan. Stat. Ann. 59- 2948(b); La. Rev. Stat. Ann. § 171B; Me. Rev. Stat. Ann. tit. 34-B, § 3803(1); Mass. Gen. Laws Ann. ch. 123, § 24; Mich. Comp. Laws Ann. § 330.1489; Miss. Code Ann. § 41-21-101; Mo. Ann. Stat. § 630.120;

Insts., 603 P.2d 123, 125 (Colo. 1979) (a "patient's common law right to decline medical treatment is * * * preserved intact[,] in the absence of some finding, reached by a competent tribunal, that the patient's illness has so impaired his judgment that he is incapable of participating in decisions affecting his health"); *Winters* 446 F.2d at 68 ("a finding of 'mental illness' even by a judge or jury, and commitment to a hospital, does not raise even a presumption that the patient is 'incompetent' or unable adequately to manage his own affairs").

And while historic practice is an important guide in describing what is "fundamental," *see Moore*, 431 U.S. at 404, this Court's Due Process cases do not allow – let alone require – that these thoroughly discredited and widely-abandoned suppositions about mental illness live on in constitutional doctrine. On the contrary, this Court, in exercising its responsibility to "to define the liberty of all," *Casey*, 505 U.S. at 850, has refused to give weight to distinctions (even if long-held) that are rooted in misunderstanding or prejudice. Thus, in *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942), the Court refused to countenance a law that denied fundamental liberties to individuals based on "highly technical" distinctions (citing the danger of "unwitting," invidious discrimination), and *Loving v. Virginia*, 388 U.S. 1 (1967), even more squarely

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Mont. Code Ann. § 53-21-141; Neb. Rev. Stat. §83-1066(1); Nev. Rev. Stat. Ann. § 433A.460; N.H. Rev. Stat. Ann. § 135-C:56(II); N.J. Stat. Ann. § 30:4- 24.2(c); N.M. Stat. Ann. § 43-1-5; N.Y. Mental Hyg. Law § 29:03; N.C. Gen. Stat. § 122C-203; N.D. Cent. Code § 25-03.1-33; Ohio Rev. Code Ann. § 5122.301; Okla. Stat. Ann. tit. 43A., § 1-105; Or. Rev. Stat. § 426.295(1); S.C. Code Ann. § 44-17-580(2); Tenn. Code Ann. § 33-3-104(5); Vt. Stat. Ann. tit. 18, § 7706; Va. Code Ann. § 37.1-87; Wash. Rev. Code Ann. § 71.05.450; W. Va. Code § 27-5- 9(a); Wis. Stat. Ann. § 51.59; Wyo. Stat. Ann. § 25-10- 121.

rejected the notion that longstanding practices concerning "interracial" marriage should be incorporated in the definition of that right. *See Casey*, 505 U.S. at 847-48; *id.* at 864 (noting that rationale for *Plessy v. Ferguson* "was so clearly at odds with the facts apparent to the Court [by] 1954 that the decision to reexamine *Plessy* was * * * not only justified but required").

Without requiring that all distinctions based on mental illness be treated as suspect, *see City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432 (1985), this Court's precedents instruct that, where fundamental liberties are involved, conclusory and inaccurate labels may not supply the basis for disparate treatment. *See Skinner*; *but cf. Buck v. Bell*, 274 U.S. 200, 207 (1927) (sustaining involuntary sterilization of an "imbecile," asserting that "[t]he principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes").

D. Involuntary Medication Of Criminal Defendants Warrants Distinct Scrutiny

Although fundamental to any individual, these liberty interests take on distinct importance in the setting giving rise to this case: where government seeks to medicate for the purpose of bringing Petitioner to trial on criminal charges. This forcible drugging occurs at a juncture when his future physical liberty (and not only his bodily and mental integrity) hangs in the balance – and where the Constitution confers a distinct set of special trial rights. U.S. CONST. amends. V, VI.

At the outset, unlike in other instances, where it proceeds as *parens patriae*, with no purpose other than the individual's own well-being, the government here stands as Petitioner's adversary, with the avowed objective of restoring competence, so that he can be tried, convicted, and punished. Thus, while *Riggins* limits drugging to that which is "medically appropriate,"

> [i]t defies reality to describe the process primarily as one * * * to make the defendant well or to make others safe. Either result may occur, but these are distinct from the ultimate legal consequence of enabling the criminal prosecution.

Siegel, 2001 WIS. L. REV. at 358. *See United States v. Gomes*, 289 F.3d 71, 84 (2nd Cir. 2002) ("the government's interest in involuntary medication ceases with the completion of the legal proceedings"); *Ferguson v. Charleston*, 532 U.S. 67 (2001).

In such circumstances, and where (as here) the individual's treating psychiatrists are the government's witnesses, *cf. Estelle v. Smith*, 451 U.S. 454 (1981), the seeming protection offered by requiring findings of "medical appropriateness," "likelihood of restoring competence" and "[that] side effects do not overwhelm benefits" may prove illusory. *See* 282 F.3d at 568-71.

Further, as both the Court's opinion and Justice Kennedy's concurrence in *Riggins* highlight, the rights that are conferred on Petitioner and others as part of the trial process can be compromised in myriad, serious ways by the effects of the drugs the government administers:

> Psychotropic drugs can interfere with a defendant's ability to exercise [trial] rights by causing sedation, producing feelings of restlessness and anxiety, diminishing awareness of and interest in events happening in the surrounding environment, disrupting memory, and inducing all manner of motor disturbances. Administering involuntary psychotropic medications is likely to impair many abilities necessary for presenting a defense, including the ability to pay attention to what witnesses, or the attorneys, or anyone else in the courtroom is saying; to offer comments or suggestions or otherwise engage in a dialogue about the

> trial; to understand and respond to questions while testifying; and even to decide whether to testify. By administering involuntary antipsychotic medications, the government interferes with the defendant's general right to be present, as well as with his more specific rights to receive effective assistance of counsel, to confront witnesses, to present evidence, and to testify on his own behalf.

D. Klein, *Note, Trial Rights and Psychotropic Drugs: the Case Against Administering Involuntary Medications to a Defendant During Trial*, 55 VAND. L. REV. 165, 191 (2002) (quotations and citations to *Riggins* omitted).[11]

[11]Nor is it an answer that diminutions in the accused's ability to participate in the trial proceedings are constitutionally inconsequential – on the ground that his overall "competence" has been restored. Many of the types of trial prejudice identified in *Riggins* are wholly unrelated to the matters decided in a competence inquiry, *see, e.g.*, 504 U.S. at 142 (Kennedy, J., concurring in judgment) (discussing prejudice relating to "defendant's behavior, manner, facial expressions, and emotional responses"). Moreover, that it is constitutionally "fair" to try a minimally competent individual does not establish that the same should be said of a trial where the prosecution (even unintentionally) used its power over the accused to disable him to a point just short of incompetency. *Cf. id.* at 139 (noting connection between forcible medication and evidence manipulation).

II. The Interest In Attempting To Restore Competence To Stand Trial Is Not Compelling

As just noted, unlike medical interventions grounded in *parens patriae* and police powers, the power invoked here – to breach Petitioner's bodily and mental integrity, in order to proceed against him – fits uncomfortably with our tradition of adversarial justice, where individual autonomy is "rudimentary," and the prosecution is required "to shoulder [its] entire load," *Murphy v. Waterfront Comm'n*, 378 U.S. 52, 55 (1964).[12] Accordingly, some courts have questioned whether the government interest relied on below – in "'obtaining an adjudication of [a defendant's] guilt or innocence'" 282 F.3d at 567 (quoting *Riggins*, 504 U.S. at 135) – "could ever be deemed sufficiently compelling to outweigh a criminal defendant's interest." *Bee v. Greaves*, 744 F.2d 1387, 1396 (10th Cir. 1984); *see also Rivers* 495 N.E.2d at 343 n.6 (rejecting "[a]ny implication that State interests unrelated to the patient's well-being or those around him can outweigh his fundamental autonomy interest").

Although the question need not be answered here for every conceivable case, *see* 123 S. Ct. 512 (2002) (limiting grant of *certiorari* to whether the Constitution allows

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[12]Whether drug-obtained trial participation could be "testimonial" under the Court's Self-Incrimination Clause doctrine, *see Schmerber v. California*, 384 U.S. 757 (1966), the severity and intrusiveness of government action shares much greater affinity with powers denied the prosecution as "conscience-shocking" and "unreasonable," *Rochin*; *Winston*; *cf. Tennessee v. Garner*, 471 U.S. 1, 11 (1985), than with cases where a defendant gives a blood or hair sample.

Nor is Petitioner's situation fairly analogized to that of the defendant in *Illinois v. Allen*, 397 U.S. 337 (1970), who was held to have chosen to absent himself from the proceedings, by wilful refusal to conform his behavior to the court's standards. Petitioner has been given no choice.

medication "to render [Petitioner] competent to stand trial for non-violent offenses"); *see generally* 282 F.3d at 573 (Bye, J., dissenting) (noting that Petitioner's guideline sentence would be in 33 to 41-month range), we submit that "careful," *Reno v. Flores,* 507 U.S. 292, 301 (1993), consideration of the government interest described, in light of this Court's precedents, establishes that it does not rank among those properly recognized as "compelling."[13]

To begin with, government's legitimate interest is not in an adjudication *per se*, but rather in one that is fair and accurate. *Ake*, 470 U.S. at 79 (no legitimate "interest in maintenance of a strategic advantage over the defense, if the result of that advantage is to cast a pall on the accuracy of the verdict obtained"); *Berger v. United States*, 295 U.S. 78, 88 (1935). Even if forcible drugging "succeeds" in rendering Petitioner minimally competent, that same governmental action can undermine – in inexact ways – both fairness and accuracy. *United States v. Brandon*, 158 F.3d 947, 960 (6th Cir. 1998) ("[A] drug that negatively affects [the defendant's] demeanor in court or ability to participate in his own defense will not satisfy the government's goal of a fair trial").

Further, the government interest asserted, although undoubtedly related to the long-acknowledged interest in "preventing and punishing criminality," *United States v. Weston,* 255 F.3d 873, 880 (D.C. Cir. 2001), is more complex and attenuated. Obtaining a conviction of a culpable individual may be of broad societal concern, *see id.* (citing interests in "demonstrating that transgressions of society's prohibitions will be met with an appropriate [punitive] response"), but the

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[13] Just as "'Substantive due process' analysis must begin with a careful description of the asserted right," 507 U.S. at 301, similar care is warranted in describing an ostensibly compelling government interest.

constitutionally contemplated alternative "adjudication"– acquittal – implicates wholly different concerns.[14] Putting aside the danger that medication will lead to wrongful conviction, it is jarring to assert that the government has a "compelling interest" in administering medication to an individual, over his objection (potentially causing him lifelong injury by so doing) – so that a verdict of "not guilty" might be rendered. *Cf. Shaw v. Hunt*, 517 U.S. 899 (1996) (rejecting that State "interest in avoiding expense and unpleasantness of litigation * * * *regardless of possible outcome of that litigation*" can be compelling) (emphasis added).

Equally important, denying the government the power to forcibly medicate postpones, but does not necessarily preclude, a later adjudication, and in the intervening time, the government's interest in incapacitation – a significant strand of its police power interest – may be served. *See* 18 U.S.C. § 4246(a). And, accepting the (implausible) assumption that different treatment of the small class of defendants adjudged incompetent and unwilling to take drugs affects the government's broader deterrence interests, it might be noted that Petitioner's lengthy, often solitary, confinement, whether or not "punishment" in the constitutional sense, would surely

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[14]Even this formulation – by assuming that medication will result in an adjudication, one way or another – overstates the fit between the interest and the means defended, omitting the possibilities (substantial here) that: competency will not be restored; that "restoration" will be temporary; or that other trial rights will be impaired in such a way that a verdict cannot not be entered. *See Cooper v. Oklahoma,* 517 U.S. 348, 366 (1996) (stressing society's interest in avoiding conviction of an incompetent defendant).

The *Weston* court did not dwell on the prospect that, given the defendant population at issue, many individuals, if "restored" and tried, would both acknowledge "transgressions of society's prohibitions" but, by reason of insanity, avoid any penal "response."

not be without deterrent effect.[15]

Finally, unlike other, more truly compelling interests, the interest in prompt adjudication on the merits is one the government regularly subordinates to other, sometimes mundane objectives. *See Greater New Orleans Broadcasting Ass'n, Inc. v. United States*, 527 U.S. 173 (1999) (evaluating government interest in light of "exemptions and inconsistencies"). Although setting aside a guilty verdict rendered in a proceeding that was fair to the defendant is a rare occurrence, *see, e.g., Powers v. Ohio*, 499 U.S. 400 (1991), the ostensibly "overriding" interests in bringing a case to trial promptly or obtaining full adjudication frequently give way. *See, e.g., North Carolina v. Alford*, 400 U.S. 25 (1970) (plea may be accepted without resolving defendant's factual culpability); *United States v. Ewell*, 383 U.S. 116 (1966) (delay is permissible under Sixth Amendment, because "orderly expedition" is more important than "mere speed"); *see also Doggett v. United States*, 506 U.S. 647, 665 (1992) (Thomas, J., dissenting) (noting competing societal interest in "repose," expressed in ubiquity of statutes of limitations).

Conclusion

For the reasons stated herein, *Amicus* requests that the Court reverse the judgment of the Court of Appeals.

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[15] It also bears mention that disabling government from taking action of this character does not undermine its interest in enforcing a particular law or class of laws. Government efforts to forcibly administer drugs – and individual assertions of constitutional protection – appear, infrequently, in a wide variety of types of criminal case. *Compare Schmerber* (government's power to enforce laws forbidding intoxicated driving dependent on blood test).

Respectfully submitted,

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