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Psychopharmaceutical Restoration to Present Sanity (Mental Competency to Stand Trial)

Defendants considered under the influence of drugs have usually been found to be mentally incompetent to stand trial. In recent years the advent of psychopharmaceuticals in treatment of the mentally ill has created a number of interesting questions for psychiatry and law. How should the mentally ill defendant under the influence of psychotherapeutic drugs be considered? How mentally impaired should such a defendant be in order to be considered mentally incompetent to stand trial? What legal standards apply? Does the standard for level of competency differ, if the defendant is on psychopharmaceuticals? If his mental impairment has improved under the influence of drugs, should these drugs be removed in order for him to demonstrate his capacity for mental competency without drugs? If so, how long should such a drug-free period be before his return to trial? Should he be denied the right to stand trial while still under the influence of such drugs? If he relapses into mental illness after psychotherapeutic drugs have been discontinued, how does this affect his mental competency to stand trial? If he demonstrates that he requires ongoing medication for continued suppression of his impairing symptoms, can he then be returned to trial while under the influence of these drugs? For how long a period of time on drugs during which time he demonstrates mental competency to stand trial should he be considered mentally incompetent to stand trial? And finally, what trends are visible in the psychiatric and legal literature that predict the future direction of psychiatry and law in answering these questions?

The law holds a defendant mentally incompetent to stand trial because of his demonstrated mental impairment, *not* because he is under the influence of drugs or is suffering from any physical or mental illness, disorder, disease, or defect. In other words, for this issue the law is unconcerned about the cause of the mental impairment but rather directs attention to its demonstrable effects upon (1) the defendant's capacity to understand the charges against him and the significance of his involvement with the criminal-legal system, as well as, (2) his capacity to cooperate with counsel in his defense. This two-pronged legal standard rather simply spells out the *what* of mental competency to stand trial.

But the *degree* of mental impairment necessary for the defendant to be incapable of these functions is not spelled out. The law is silent on the critical threshold level of mental impairment that separates the condition of mental competency from mental incompetency.

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In previous articles [*1*,*2*] the following have been pointed out: (1) the threshold level of mental impairment for mental incompetency to stand trial is arbitrary and defined by social policy to fulfill social needs through law; (2) for mental incompetency to stand trial, a high threshold level of mental impairment is set rather than a low threshold level. In other words, more mental impairment, rather than less, is required before a mentally ill defendant is considered mentally incompetent to stand trial. This social policy is derived from a number of interrelated factors such as the presumption of mental competency to stand trial, the accused's constitutional right to a speedy trial, and pressures from the over crowded system of criminal justice to process defendants through the system as quickly as possible. An analogy can be drawn from the high degree of visual impairment that is held to be necessary before a visually defective person can be considered blind for purposes of receiving social welfare benefits. Although entirely arbitrary, nevertheless, more visual impairment, rather than less, is needed for the patient to qualify for this definition of legal blindness.

(3) The same legal standard of mental competency to stand trial operates whether the defendant moves from the state of mental competency to stand trial to mental incompetency, or returns from mental incompetency to the state of mental competency to stand trial; and the same high threshold level of impairment should obtain for both movements. Nevertheless, the high threshold level of mental impairment appears to drop for the mentally ill defendant-patient found mentally incompetent to stand trial who seeks to regain his mental competency. Once the defendant has been legally adjudicated as mentally incompetent to stand trial, it appears that more is demanded of him to demonstrate his mental competency to stand trial than was expected of him before the adjudication of incompetency. He continues to be considered mentally incompetent even though he demonstrates less mental impairment. The critical level separating mental incompetency from mental competency appears to have dropped.

This change may result from the fact that the burden now on the defendant is that of demonstrating his mental *competency*, whereas before he was presumed mentally competent and his burden was on demonstrating his mental *incompetency;* and there is obvious greater difficulty in demonstrating "normality" as against pathology. Also the psychiatrist is more cautious in denying impairment in a patient with an already legally established mental incompetency as against his minimal concern about demonstrating mental impairment to establish mental incompetency. The physician's therapeutic bias, his sympathy for the impaired mentally ill defendant-patient and his resistance to returning the defendant patient to the stresses of trial and possible penal sanctions would also lead the psychiatrist to lower the critical level of mental impairment required for mental incompetency to stand trial.

(4) The goal of psychiatric treatment of the mentally ill defendant-patient is his restoration to (present) sanity, that is, his return to mental competency to stand trial. With this objective the therapist must be cautious about how his treatment modalities effect this goal, for example, he would hesitate to use memory impairing electrical treatment. Psychopharmaceutical agents which reduce clinically apparent psychopathology may also have untoward physical or psychic effects. Although the legal goal must be considered primary, nevertheless, once the defendant assumes a mentally ill patient role, the psychiatrist becomes concerned with the patient's overall mental condition and frequently by-passes or ignores the specific legal definition of mental illness that is carried by this mentally ill defendant-patient. This defendant-patient is defined as mentally ill only for the legal purpose of his mental incompetency to stand trial. In this sense he is no longer

mentally ill as soon as he is mentally competent to stand trial, no matter how mentally ill he may be psychiatrically or for any other legal purpose.

Using the blind-sighted patient analogy, as soon as this patient's visual impairment can be reduced below the critical level of legal blindness, he is no longer eligible for social welfare benefits to the totally blind. If his blindness can be improved with drugs, surgery, or special spectacles to the point that he is considered sighted, then he loses his special distinction even though he may continue with a considerable degree of visual impairment.

(5) Identification of the defendant as mentally competent or incompetent is more difficult as the patient gets closer to the critical threshold level. Definitions are clearer, evaluations easier and judgments offered with greater confidence about mental competency to stand trial as the defendant-patient's degree of mental impairment is farther removed from the critical level. Risk of error in judgment formation is lowest at the polar extremes most distant from the threshold level. Fluctuations (in the patient's mental impairment) close to the critical level are most difficult to evaluate, and opinions regarding mental competency of this defendant hold the lowest level of confidence. It is obvious that the distinction between blindness and sightedness is most difficult near or at the critical threshold level arbitrarily separating these two states.

(6) The reduction in mental impairment by means of psychopharmaceutical agents should present no legal barrier to restoration to sanity. Drug treatment can be considered as a model for reducing mental impairment, drugs being tools for restoring, rebalancing, and normalizing impaired psychic functions that are required for mental competency to stand trial. In the same way, the use of spectacles should be no bar to reduction of the state of blindness. If the visually impaired individual can see well enough with spectacles to pass the test for sightedness, he is sighted, not legally blind. True he will be blind without his spectacles; but if the arbitrarily determined critical level of sightedness is defined as that degree of visual acuity that can be attained through any means, aid, or tool, then he is identified as a sighted person even though he would be better off if he could reach this level of visual acuity without glasses.

(7) A conflict exists between this model of the normalizing effects of drugs with reduced mental impairment and the traditional model of drug influence (upon the defendant) with increased mental impairment manifested by blunting of the sensorium, clouding of consciousness, dulling memory, impairing judgement and reason, creating emotional dysbalance and producing motor dysfunctions in communication. This conflict in models has led to legal confusion, promoting in some judges (and psychiatrists) the impression that the mentally ill defendant-patient should not be returned to stand trial while he is still under the influence of psycho-active drugs, even though with such drugs he qualifies for the legal standard of being mentally competent to stand trial. Using the analogy of the blind-sighted patient, unless this patient is capable of seeing without spectacles he is still considered legally blind. This paper directs itself to a challenge of this latter position and describes trends in law that support this challenge.

Discussion

In 1951 a French anesthesiologist observed that patients premedicated with a new pharmaceutical agent demonstrated little to no anxiety in regard to their pending operation, although they appeared fully conscious of the surrounding pre-operative procedures. As a result of both pre- and post-operative observations, a new era in psychiatric therapy was initiated when the clinical effects of the phenothiazine derivative (RP 4560, Chlorpromazine) were investigated on agitated psychiatric patients [*3,4*].

In 1953 Chlorpromazine became available in the United States for purposes of drug investigation; and since that introduction, the antipsychotic "major tranquilizers" (phenothiazine derivatives, antidepressives, and other psychotropic agents, as well as the so-called "minor tranquilizers") have become widely prescribed drugs.[3]

The efficacy of these psycho-pharmaceutical agents is well documented through dramatic shortening of length of hospitalization with readmissions correlated with cessation of maintenance medication [5]. Many patients on drugs are able to continue with all of their customary daily activities with their overt psychotic symptomatology held in remission through the use of maintenance dosage of psychotropic medication. Despite this enviable record trial courts have raised the issue of a defendant's mental competency to stand trial while he is receiving a therapeutic maintenance dose of medication which produces remission of the very symptoms that caused him to be previously adjudicated as "mentally incompetent to stand trial."

Although there can be no disagreement with the dicta expressed in *Hayes v. United States*,[4] "[It] is hardly necessary to add that certainty as to the lack of any mental effects from drugs upon a defendant during his trial and conviction, is a matter of particular judicial solicitude," (cf. *Pledger v. United States*),[5] it unfortunately appears as if some courts interpret "effects from drugs" to such an extreme that they may be denying the defendant those very rights which they are trying to safeguard.

Some hospitals refuse medication to a patient prior to his appearance at criminal-legal proceedings [6,7], "in order to present him [defendant-patient] in his real face before the court."[6] The following is an excerpt from the appellate decision of *Ohio v. Rand*,[7] which illustrates the psychiatric reasoning for discontinuing Stelazine and Thorazine medication in December (12–2–68) in preparation for a trial hearing to be held three months later (3–14–69),[8]

Q. (Court) Why was he taken off, then?

A. (State hospital staff psychiatrist) Why? Because we knew he was to appear in court.

[3] The term "tranquilizer" was first used by Benjamin Rush, M.D., founding father of American Psychiatry, in describing his "tranquilizing chair." The term came into general usage very recently, designating a group of pharmaceutical agents which reduce anxiety and agitation. Unfortunately, the term continued to be applied to more sophisticated psychopharmacological agents (Chlorpromazine, etc.) which, in addition to reducing anxiety—"tranquilization"—also possessed specific psychopharmaceutical properties to produce remission of clinically overt psychotic symptoms. Thus "tranquilizer" is a misnomer and tends to mislead and misinform the psychiatrically unsophisticated into assuming that reduction of anxiety and agitation is their only function. Please note the titles of the following articles as examples of this misinformation: (1) "Tranquilizers and 'Recovery to Legal Sanity'" [*10*]; (2) "The Case of the Tranquilized Defendant," Moseley, M., *Louisiana Law Review*, Vol. 28, 1968, pp. 265–269; (3) "Tranquilizers and the Psychotic Defendant" [*11*]; (4) "The Propriety of Using Tranquilizing Drugs to Calm a Person to the Point Where He is Competent to Stand Trial" *see* ftn. 8; (5) "Tranquilizers and Competency to Stand Trial, "Buschman, Reed, *ABA Journal*, March 1968, Vol. 54, pp. 284–287.

In order to eliminate this confusion, we have used the non-specific term "psychotropic medication" to designate all pharmaceutical compounds which possess an effect upon the central nervous system. "Antipsychotica," or antipsychotic agents, would be an appropriate term to designate those substances which reduce or eliminate psychotic symptomatology, and "tranquilizers" would be restricted to drugs whose major function is to reduce anxiety and agitation. Such a classification would eliminate the confusion as demonstrated in the titles listed above where the term "tranquilizer" was used, but "antipsychotica" was meant.

[4] *Hayes v. United States*, 305 F.2d 540, 543 (1963).

[5] *Pledger v. United States*, C.A. 4 Va.; 272 F.2d 69, 70 (4th Cir. 1959).

[6] *Ohio v. Rand*, 20 Ohio Misc. 98, 247 N.E. 2d 342 (1969).

[7] *Id.* note 11, at 347.

[8] Quite possibly, medication was discontinued as early as 18 October 1967. For a full discussion as to the legal reasons for this, refer to: Hoellrich, *The Propriety of Using Tranquilizing Drugs to Calm a Person to a Point Where He is Competent to Stand Trial, State v. Rand*, 31 Ohio State L.J. 617 (1970). It appears as if the State Hospital acted in agreement with the prosecutor so as to prevent Rand from achieving competency through the use of psychopharmacological agents (at 619).

And be present as a normal human being can in order to get release. And our statement is that he is insane and should be kept in a hospital for mental ill.

Q. All right. Now, that is the opinion we are trying to get at. From your testimony, the only reason that tranquilizing drugs were withdrawn from the defendant, even though you knew he should receive them everyday, was because of the fact that he was going to appear in court, is that right?

A. In order to present him in his real face before the court.

It should be noted that the above reasoning is not at all related to the issue of "restoration of mental competency to stand trial." Perhaps the hospital psychiatrists were influenced by their therapeutic bias or their bias against the criminal sanctions imposed upon those convicted for murder. But the court examined further.

Q. In his real picture. Let's assume that—would the tranquilizing drugs have any effect upon his ability to think?

A. Yes.

Q. What would this effect be?

A. That he acts like a normal human being.

Q. In other words, he would think clearly?

A. In behavior, in talking, in actions.

Q. In other words, with the tranquilizing drugs he would behave as a normal person

A. Almost like a normal human being. There is no actual signs of active psychosis when he is on medication of tranquilizing drugs.

Q. Now, with the use of tranquilizing drugs, would Mr. Rand be able to understand, in your opinion, be able to understand the nature of the charges against him?

A. Without drugs?

Q. With drugs.

A. With drugs, yes.

Q. With drugs. In your opinion, would Mr. Rand be able to counsel in his own defense?

A. I assume.

Q. Counsel with his attorneys in his own defense?

A. I may assume yes, because he still gets a little moody, suspicious all the time. Everyone is sometimes suspicious.

Q. That is the point we all, from time to time, become moody, depressed, suspicious, even sometimes hostile.

A. Yes.

Q. But with the drugs, it is your opinion he would be able to counsel with his lawyers in his own defense.

A. Yes.

In *Ohio v. Rand*, the specific issue raised was:

Whether the defendent is competent to stand trial if tranquilizing drugs are administered under proper medical direction which permit the defendant to communicate with his counsel in an apparently reasonable and rational manner, as to the preparation and conduct of his defense to the pending charge of murder in the first degree.[9]

[9] *Id.* note 11, at 343.

It was held by the court:[10]

> The defendant is competent to stand trial, under properly administered tranquilizing drugs that permit him to counsel with his lawyers, as the test is set forth in the *Bushong*[11] and *Dusky*[12] cases.

The use of psychotropic medication to eliminate psychotic symptomatology has been adjudicated by other courts in similarly favorable light. In *Louisiana v. Plaisance*,[13] it was held that the trial court did not err in ruling that the defendant, who had twice been adjudicated incompetent to stand trial, was competent to stand trial even though she was receiving psychotropic medication (type unspecified—"under sedation . . . being in a state of remission due only to said drugs"[14]) at the time of the third hearing.

After psychiatric testimony stated that psychotic symptomatology was held in remission through the use of Thorazine (100 mgm qid), and that the patient-defendant would probably relapse if the dosage were discontinued, but "[At] the present time, she's legally sane, and she is legally sane due to medication," the trial judge found the defendant to be only "synthetically sane"; and concluding that trial capacity induced by medication was insufficient, he ruled the defendant to be incompetent to stand trial.[15] Upon appeal, the appellate opinion held that the defendant was competent—"under the codal test, the court looks to the condition only. It does not look beyond existing competency and erase improvement produced by medical science. . . . The likelihood that defendant will relapse if the use of the medication is interrupted does not bar her from proceeding to trial."[16]

The same philosophy is expressed in *People v. Kadens*,[17] where the Illinois Statutory wording, "permanently recovered" was interpreted in this way: " 'permanently' does not mean an absolute condition for all future time, but only the condition to be found was full and permanent recovery at the present time, and that such condition was reasonably certain to continue."[18]

Dhaemers v. Minnesota[19] expanded and distinguished the concept of full and permanent recovery when this opinion expressed the theory that if the defendant were adjudicated incompetent to stand trial, it was not necessary that there be a complete restoration prior to trial; "He need be recovered only to such a degree as to be capable of understanding the proceedings and making a defense thereto."[20] This opinion implies that psychotic symptomatology may still be present, but that the effects of medication must effect sufficient remission of that specific symptomatology which prevents the defendant from being adjudicated as "restored to sanity."

It is important to note that *none* of the decisions cited above, states that under a *specific medication* (or at a specified dosage thereof), the patient-defendant is to be determined as mentally competent to stand trial. The cases judicially determined the patient-defendant's present capacity to understand the charges and proceedings, and to assist counsel rationally, *and the legal determination is made only on this basis.*

[10] *Id.* note 11, at 349.
[11] *State ex rel Townsend v. Bushong*, 146 Ohio State 271, 273, 65 N.E.2d, 407 (1946), of *Ohio v. Rand*, *op. cit.* 345.
[12] *Dusky v. United States*, 362 U.S. 402, 80 S.Ct. 788, *cf. Ohio v. Rand*, *op. cit.* 345.
[13] *Louisiana v. Plaisance*, 210 So.2d 323 (1968).
[14] *Id.* note 18, at 325.
[15] *Louisiana v. Hampton*, La. 218 So.2d 311 (1969).
[16] *Id.* note 20, at 312.
[17] *Illinois v. Kadens*, 78 N.E. 2d 289 (1948).
[18] *Id.* note 22, at 2920. This was an adjudication for restoration to sanity so that the defendant could stand trial. No mention was made of the use or non-use of medication.
[19] *Dhaemers v. Minnesota*, 175 N.W.2d 457 (1970).
[20] *Id.* note 24, at 460.

Medical restoration to sanity by means of psychotropic drugs raises additional questions with respect to the effect of these drugs upon the defendant and the effect of the drug-influenced defendant upon the trier of fact. The defendant pleading diminished capacity or insanity presents a much more persuasive picture for his defense if he provides a clinical picture of more severe mental illness to the trier of fact during the trial. Consequently the defendant's improvement in mental and emotional functions, and particularly improvement in his courtroom appearance, talk, and conduct may do a disservice to his psychiatric defense. A "normal" appearing defendant has more difficulty pleading insanity; and, in fact the mentally ill defendant under the influence of drugs may present himself as so tranquilized in the courtroom that he may mislead the trier of fact to believe that he is insensitive, callous, and incapable of remorse.

Normalizing effects of psychotropic medication can prove detrimental to the defendant in the sense that following a determination of being "mentally competent to stand trial," the patient-defendant faces the possible consequences of being adjudicated guilty of a crime (which may well be long-term imprisonment or even execution). The trial judge in *Louisiana v. Burrows*[21] raised the following issues (but did not rule on them):

> Query: Is this sanity produced by medication the legal sanity contemplated by the law sufficient to place a defendant on trial for his life, or can he be kept confined in a mental institution for the rest of his life, even though he is sane enough to be released because of the administration of medication?
>
> Can he be compelled to take drugs that will produce sanity sufficient for him to stand trial and, if found guilty of the death penalty, compelled to take drugs so that he may remain sane in order that his life may be taken?

Ethical questions can arise regarding volitional versus non-volitional medicating of the mentally ill defendant. Again from *Louisiana v. Burrows:*[22]

> The court appears to be impaled on the horns of a dilemma. It is not beyond the realm of conjecture to have a situation wherein a defendant under medication is found sane yet, before trial he refuses to take medication and reverts to his former condition so that he cannot be tried and has to be recommitted. In other words, a defendant can control his mental situation by either taking or refusing to take medication.

A roughly analogous situation occurred in *California v. Rogers*[23] when the defendant, an experienced diabetic, took a large dose of insulin on the fourth trial day, and willfully abstained from eating breakfast, thus experiencing a self-imposed insulin shock. The court felt the defendant, by his own actions, induced the mental state whereby he could not assist at time of trial, and the court held that this amounted to a waiver of the right to be mentally present (the defendant had been previously granted 13 continuances based upon ill health).

It appears by extrapolation of the above, that a patient-defendant may be placed in the position of choosing between receiving medication which *might* produce remission of the symptoms causing him to be held "mentally competent to stand trial," or facing the risk of waiving his rights to be mentally present at time of trial.

Although no appellate cases have arisen as yet, a patient-defendant who has been unwillingly adjudicated as restored to sanity might raise the issue of drug-induced tranquility which detrimentally influenced his demeanor at time of trial. Analogous situations

[21] *cf. Louisiana v. Burrows*, 250 La. 658, 198 So.2d 393, 394 (1967).
[22] *Id.* note 26, at 394.
[23] *California v. Rogers*, 309 P.2d 949, 959 (1957).

have occurred where the defendant, under the medically beneficial influence of tranquilizing medication, has stood trial and following adjudication as "guilty", has appealed the verdict because of alleged "detrimental changes" in his mental competency produced by the pharmaceutical agent.

In *Oregon v. Hancock*[24] it was held that if tranquilizers were prescribed to the defendant to assist him in handling his emotions beginning with the week prior to trial and continuing to the conclusion of the trial, and that if these drugs (Valium) did not impair his ability to communicate with other people, or his memory, and that if they did not impair his mental function, and that if it were shown that the defendant actively participated in his trial, it was then not an abuse of judicial discretion to determine that the defendant has a fair trial.

In a similar case, *State v. Murphy*,[25] an appellant from a murder conviction was shown to have been extremely nervous, taut, and anxious before trial and was given tranquilizing pills by a medical trusty of the county jail on the morning he testified in his own behalf. He was without knowledge of the content or effect of the pills (Equanil and Trancopal) which completely changed his demeanor on the witness stand, so that he was casual, cool, and unperturbed. It was held that the trial court erred in failing to grant the defendant's motion for a new trial, because the changed attitude and demeanor of the defendant, as observed the jury, could have influenced them in recommending the death sentence.

The two cases are differentiated by the defendant's observable behavior (as a demonstrable result of mental function). In *Oregon v. Hancock*,[26] the defendant actively participated in his defense without impairment of mental or emotional functions. In *State v. Murphy*,[27] there had been a marked and significant change in the defendant's attitude so that it could have appeared to the jury that the defendant was callous and uncaring about his crime, thus providing a basis for an erroneous impression upon the jurors. These two decisions could serve as guidelines for the psychiatric interview of patient-defendants who are being evaluated for restoration to sanity while under the influence of psychotropic medication.

The prescribing of potent antipsychotic drugs must be carefully evaluated by the physician. Dosages must be titrated to the patient's clinical behavior; and exact dosages should be employed. These cautions are especially important because of the potentially mentally impairing side effects of all psycho-active drugs, their dulling effects upon the sensorium, their reducing effects upon alertness, and their paradoxical potential as psychotogenic agents.

Specific psychiatric-legal inquiries on the patient-defendant's mental competency to stand trial should be conducted regularly during the entire period of the patient's drug treatment; ongoing evaluations of the patient's level of improvement, the stability of his improvement, and fluctuations in the relationship of his mental functions to the legal issue of mental competency to stand trial should take place and should be noted in the patient-defendant's hospital chart.

The physician is well aware of his patient's individual response to medication and re-evaluates him, changing prescribed dosage so as to secure the clinically desired reaction without concomitant side effects. The psychiatrist, when evaluating a patient-defendant for the purpose of "restoration to sanity," must take into cognizance the medication prescribed and the known side effects. The reaction of the specific individual to his pre-

[24] *Oregon v. Hancock*, 426 P.2d 872, 876 (1967).
[25] *State v. Murphy*, 56 Wash.2d 761, 355 P.2d 323 (1960).
[26] *Id.* note 29.
[27] *Id.* note 30.

scribed medication must be explored, inasmuch as toxic side effects and drug failures occur unpredictably [*8*] and the plasma concentration of the medication may vary by a factor of 30 to 50 (Chlorpromazine has shown an individual variation by a factor as high as 50) [*9*].

Because of the patient's variable response to medication, a psychiatrist familiar with all possible effects of the medication must evaluate the defendant with the interview directed towards eliciting responses that are pertinent and hold probative value for the legal objective, namely, (1) the defendant's capacity for conscious, intelligent, and rational participation in the criminal-legal proceedings, and (2) the defendant's capacity for meaningful cooperation with counsel and court.

If this procedure is not followed, the result may be similar to *Carter v. State*,[28] in which the criminal conviction was reversed and remanded for a new trial. Here, an epileptic under medication appeared to be drowsy or sleepy and was mentally unable to intelligently state the facts upon which his defense rested. As the evidence was not clear, "[it] was of the utmost importance to the appellant that his mind should not be so clouded by disease or the drug administered to him . . . as not to permit him to remember and intelligently state what occurred at the homicide."

Despite the difficulty of individual variability of response to medication and ideosyncratic reactions, many defendants require long-term maintenance on psychotropic medication if they are to be adjudicated as restored to sanity, that is, mental competency to stand trial [*10,11*]. Otherwise, approximately 50 percent of such patient-defendants are doomed to spend the rest of their lives in mental institutions, awaiting restoration to sanity [*12*].

Conclusion

Psychopharmaceutical restoration to sanity for the mentally incompetent patient-defendant is a medical reality for the overwhelming majority of such individuals. The courts have recognized this advancement of science in their decisions. Although the judicial system should continue to be concerned with untoward influence of drugs upon the defendant's mental competency to stand trial, nevertheless, many courts have recognized the advances in psychiatric treatment in their decisions on present sanity. The trend in trial courts is to require the drug-influenced normalized defendant to stand trial as early as possible even though he still requires continuing psychotropic medication to retain his mental competency to stand trial.

If the mentally ill patient-defendant demonstrates adequate sustained improvement in mental impairment and can be completely taken off drugs, so much the better; but the defendant need not be taken off his normalizing drugs in order to be returned to stand trial.

The critical level of mental impairment for incompetency to stand trial should remain high so that the mentally ill patient-defendant should return to trial as soon as he qualifies for mental competency with this high threshold level of mental impairment. In other words, the mentally ill defendant should be returned to stand trial if at all possible at the earliest possible date.

The decision as to how long the patient-defendant should remain incompetent to stand trial while on normalizing drugs is a medical-legal decision affected by many variables, such as, (1) the kind of severity of mental illness presented by the patient-defendant and its expected course and outcome; (2) the patient's level of response to drug treatment as well

[28] *Carter v. State*, 21 So.2d 404 (1945).

as to all of the other treatment modalities employed; (3) his continuing level of mental impairment and the proximity of his level to the critical threshold level of mental impairment; (4) fluctuations in his mental illness; (5) fluctuations in his mental impairment—the relative stability of improvement in his mental impairment; (6) the severity of drug side effects and their special significance for mental competency to stand trial; and (7) the frequency and severity of the patient's relapses with and without psychotropic drugs.

The psychiatrists's clinical acumen is taxed by the need to evaluate and prognosticate in the absence of well-established criteria. The patient may be demonstrating fluctuations in his state of mental impairment. He should not be considered mentally competent to stand trial until he has stabilized in his mental competency for a substantial period of time, probably one to two months, although a shorter period of stable time may be adequate under certain conditions, for example, improvement from a toxic psychosis. There is also the possibility of the defendant's relapse under trial pressures. If this possibility is strong, the court should be notified of the improvement in the patient's mental impairment, the degree of stability in his remission, and the possibility of his relapse under trial pressures. Suggestions may be offered to the court concerning these pressures for the purpose of increasing the likelihood of the defendant remaining mentally competent to stand trial.

It should be stressed that the defendant-patient is mentally competent to stand trial as soon as his mental impairment remains consistently below the critical threshold level; and the court should, therefore, at that time, be notified of his improvement so that he can be restored to sanity. The court, however, should be made aware of the possibility (or probability) of the defendant's decompensation at trial in order for the court to take this into account in its legal determination of restoration to sanity. The patient-defendant must be returned to stand trial at the court's request even if there is a high probability of his relapse at trial.

In summary, for both psychiatry and law the restoration to sanity through psychopharmaceutical agents has clearly demonstrated that advantages far outweigh the legal difficulties that drug treatment may bring for the mentally ill defendant.

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